

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 13 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39205**
Registrar's No. **1721**

Registration District No. **323** Primary Registration District No. **4473**

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Blackburn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME PHYLLIS A. TAYLOR

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race 3 Negro
6. (a) Single, widowed, married, divorced 9
6. (b) Name of husband or wife Charles Taylor 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar 1 1895
(Month) (Day) (Year)

8. AGE: Years 58 Months 8 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Maltiber Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business Self

MOTHER FATHER
12. Name Miller Kyle
13. Birthplace Pettis Mo (City, town, or county) (State or foreign country)
14. Maiden name Matilda Raudius
15. Birthplace States Va (City, town, or county) (State or foreign country)

16. (a) Informant Madine Elmore

(b) Address Blackburn Mo

17. (a) Burial (b) Date thereof Nov 29 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Saltzman Mo

18. (a) Signature of funeral director F. S. Ferguson

(b) Address Sedalia

19. (a) Nov 29 43 (b) Wm. Dem. Hoffmann
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town Blackburn
(If outside city or town limits, write "RURAL")
(d) Street No. P.O. Add. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26
year 1943 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept 25 34
_____ 19____ to Nov 26 1943
that I last saw her alive on Nov 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis

Due to Lobar Pneumonia Duration 25 days

Due to _____

Other conditions (Include pregnancy within 3 months of death) 108

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) NO

(b) Date of occurrence 20

(c) Where did injury occur? NO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature L. S. Jones, M.D. (M. D. or other)

Address Blackburn, Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

Licensee File Number _____

Date Filed 12-10-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Sedalia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *11111*

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County *Lafayette*
(b) City or town *Blackburn*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Phyllis A. Taylor*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *Nov.* Day *26*
Year *1943* Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
_____ 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex *F* 5. Color or race *B*
6. (a) Single, widowed, married, divorced *Married*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *Mar.*
(Month) (Day) (Year)

Duration
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years *58* Months *8* Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____

19. (a) *Nov. 29 1943* (b) *Mrs. Doris Hoffmann*
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-39285