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FILED FEB 10 1944

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE **MO.**

(b) City or town Springfield

(c) Name of hospital or institution: 1948 N. ROBBERTSON AVE.
(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 MO. (b) County GREENE

(c) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL")

(d) Street No. 1948 N. ROBBERTSON AVE.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country..... ✓

3. (a) PRINT FULL NAME DEWEY SHELLEY TAYLOR

3. (b) If veteran, name war unk.

3. (c) Social Security No. 496-03-2158

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 18
year 1944 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from Jan 17th 1944
to Jan 18th 1944
that I last saw h. Dead alive on When Seen 1944
and that death occurred on the date and hour stated above.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife GLADYS TAYLOR

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased APRIL 16 1899
(Month) (Day) (Year)

Immediate cause of death CORONARY Occlusion Duration 20 min.

8. AGE: Years 44 Months 9 Days 2
If less than one day hr. min.

Due to.....
Due to.....

9. Birthplace PRESCOTT ARK
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 94a

10. Usual occupation Electrician

Major findings: Of operations.....
Of autopsy.....
PHYSICIAN 94a
Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name W. M. Taylor

13. Birthplace unk. unknown
(City, town, or county) (State or foreign country)

14. Maiden name unk. unknown

15. Birthplace unk. unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Gladys Taylor

(b) Address SPRINGFIELD MO.

17. (a) Removal (b) Date thereof Jan 23-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarksville Miss

18. (a) Signature of funeral director J. W. Klingner

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? Max (Specify type of place) to degrees of injury.....

23. Signature Max Taylor (M. D. or other) MO.

Address Springfield Mo. Date signed 1-19-44

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

MOTHER FATHER

484

FEB 10 1924

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 *Ogden Stone Jr.*

Licensed Embalmer No. *4176*

P. O. Address *Springfield*

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

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

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