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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21164

FILED JUN 30 1944

Registration District No. 42

Primary Registration District No. 1008

Registrar's No. 641

1. PLACE OF DEATH:

(a) County Buchanan

(b) ~~City or town~~ St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs 6 Mo 18 da. (Specify whether years, months or days)

In this community 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City 11
(If outside city or town limits, write "RURAL")

(d) Street No. 1811 Troost Ave 7
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country Jackson 0

3. (a) PRINT FULL NAME JAMES TAYLOR

3. (b) If veteran, name war Unknown

3. (c) Social Security No. none

4. Sex M V

5. Color or race Negro

6. (a) Single, widowed, married, divorced Not known 9

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased not known (Month) (Day) (Year)

8. AGE: Years about 26 | Months ✓ | Days ✓ | If less than one day ___ hr. ___ min.

9. Birthplace not known (City, town, or county) 9 (State or foreign country)

10. Usual occupation none

11. Industry or business —

FATHER
12. Name Pete Taylor
13. Birthplace not known (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name not known
15. Birthplace not known (City, town, or county) 9 (State or foreign country)

16. (a) Informant Record St Hospital

(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Asylum Cemetery

18. (a) Signature of funeral director Ramsey & Son

(b) Address 1602 Messaine St Jo Mo

19. (a) 5/10/44 (Date received local registrar) (b) Helen L. Fickle (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Month~~ 6 day May year 1944 hour 5-45 minute a M.

21. I hereby certify that I attended the deceased from 5-2, 1944, to 5-6, 1944, that I last saw him alive on 5-5, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tubercular Pneumonia	
Due to Pulmonary Tuberculosis	
Due to	
Other conditions Mental deficiency (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

13 P1

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C E Salyer 6 (M. D. ~~or other~~)

Address St Joseph Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Body Not Embalmed

....., Registered Apprentice No. .....

working under my personal supervision.

Signed J. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address .....

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

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