

V. S. No. 2
 FORM-8-43
 Rev. 5-17-39
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24092

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

UNITED STATES DEPARTMENT OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 20 1944
 Registration District No. 28

Primary Registration District No. 3006

Registrar's No. 152

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

10
2
4

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Boone county Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 11 days 10
(Specify whether)
 In this community 11 days
years, months or days

3. (a) PRINT FULL NAME William Bruce Taylor
3. (b) If veteran, name war no
3. (c) Social Security No. _____

4. Sex male **5. Color or race** w.
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Marcella Lucia Taylor
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 31 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>2</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Callaway Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business County Rep.

12. Name Robert Taylor

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

14. Maiden name Elyza Payne

15. Birthplace no
(City, town, or county) (State or foreign country)

16. (a) Informant William B. Taylor

(b) Address 109 W. 10 Fulton

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 6-22-44
(Month) (Day) (Year)

(c) Place: burial or cremation Hillcrest Cem

18. (a) Signature of funeral director Wallace Funeral

(b) Address Hone Fulton no

19. (a) 6-22-44 (Date received local registrar) **(b) Colna H. Barber** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo 14
 (b) County Callaway 1
 (c) City or town Fulton 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 109 W 10th
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
 year 1944 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from June 8, 1944, to June 19, 1944
 that I last saw him alive on June 18, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to uremia

Due to Urinary Calculi

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations Tones in Bladder
Of autopsy 1248

Duration
1 day
+
10 days

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 H. H. ... (M. D. or other)
Address Columbia Mo **Date signed** 6/24/44

1251 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-18-44

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 Dwight O. Browning

Licensed Embalmer No. 2724

P. O. Address Galton mo

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.