V. S. No. 2
00M—8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 20 1944

Registration District No. 334

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25877

Primary Registration District No. 4491

Registrar's No.

1. PLACE OF DEATH:
(a) County: Scott
(b) City or town: Diehlstadt
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at residence
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 33 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Scott 100
(c) City or town: Diehlstadt 0
(If outside city or town limits, write "RURAL") 0
(d) Street No.: none
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Nolan Everett Taylor
3. (b) If veteran, name war: no
3. (c) Social Security No. 495-14-0359

4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: married 1
6. (b) Name of husband or wife: Zola Josephine Taylor
6. (c) Age of husband or wife if alive: 39 years
7. Birth date of deceased: January 7, 1906 (Month) (Day) (Year)

8. AGE: Years 38 | Months 4 | Days 7 | If less than one day ___ hr. ___ min.

9. Birthplace: State of Indiana 1 (City, town, or county) (State or foreign country)
10. Usual occupation: Levee Worker
11. Industry or business: Mechanic Levee equipment

FATHER
12. Name: Clarence Taylor
13. Birthplace: Indiana 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Ethel McSwain
15. Birthplace: Indiana 1 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Zola Josephine Taylor
(b) Address: Diehlstadt, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 14, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Maynard Cem.-Diehlstadt, Mo
18. (a) Signature of funeral director: John F. Nunnelee Jr
(b) Address: Sikeston, Mo
19. (a) (Date received local registrar) (b) Mrs E. J. Nunnelee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th year 1944 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from Attended as Coroner-No medical 19__;
that I last saw the deceased alive on Attendance 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death: BODY DISMEMBERED BY EXPLOSION OF DYNAMITE & DYNAMITE CAPS — Duration

Due to:

Due to: 19521

Other conditions (Include pregnancy within 3 months of death): 99

Major findings:
Of operations:

Of autopsy:

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): UNDETERMINED 100
(b) Date of occurrence: MAY 14 1944
(c) Where did injury occur? Diehlstadt Scott Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home in back yard (Specify type of place)
While at work? (e) Means of injury

23. Signature: Clyde Poe 3 Coroner (M. D. or other)
Address: Sikeston Mo Date signed 7/6/44

1220 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 744-939
Date Filed 7-7-44

AUG 20 1945

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 BODY NOT EMBALMED

Licensed Embalmer No. .....

P. O. Address .....

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.