

FILED OCT 24 1944

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 4015

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

1. PLACE OF DEATH:

(a) County JACKSON  
 (b) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: ST. LUKE'S HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day  
 In this community 3 yrs.  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON  
 (c) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. STATE HOTEL-124 STATE WY AND OTE  
 (If rural, give location)  
 (e) Citizen of foreign country? (Yes or No) No  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROBERT MORRIS TAYLOR

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 2 17 1888  
 (Month) (Day) (Year)

8. AGE: Years 54 Months 7 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Omaha, Neb.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Federal Reserve Bank

11. Industry or business \_\_\_\_\_

12. Name Robert M. Taylor Sr.

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

14. Maiden name Elizabeth Burke

15. Birthplace M. N.  
 (City, town, or county) (State or foreign country)

16. (a) Informant MRS. MARY WIDDEBRAWST

(b) Address Omaha NEBRASKA

17. (a) Removal (b) Date thereof Oct. 6, 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Omaha, Neb.

18. (a) Signature of funeral director W. H. Newcomer

(b) Address 1401 E. Wash. Creek Blvd.

19. (a) 10-6-44 (b) D. E. Brown  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 5  
 year 1944 hour 12 minute 15 M.

21. I hereby certify that I attended the deceased from Pathologist, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him alive on OCT. 5-, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to 107

Other conditions Circulatory collapse  
 (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy as above

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? \_\_\_\_\_

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

23. Signature Walter E. Jones (M. D. \_\_\_\_\_)

Address St. Louis, Mo. Date signed 10-6-44

**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

*Cesar Tortkey*

Licensed Embalmer No.

*1767*

P. O. Address

*12 E 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.**