

FILED JAN 1 1945

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 47

1. PLACE OF DEATH:

(a) County: FRANKLIN
(b) City or town: SULLIVAN
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NORTHSIDE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hr.
(Specify whether In this community 1 hr. 45 minutes years, months or days)

3. (a) PRINT FULL NAME: UNNAMED TAYLOR

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: FEMALE 5. Color or race: WHITE 6. (a) Single, widowed, married, divorced, child

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: December 12 1944 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 1 hr. 45 min.

9. Birthplace: Sullivan Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Infant

11. Industry or business _____

12. Name: Edmed Taylor

13. Birthplace: Leslie Mo. (City, town, or county) (State or foreign country)

14. Maiden name: Ruby Beard

15. Birthplace: Texas Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Almed Taylor

(b) Address: Sullivan Mo.

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: Dec 13 44 (Month) (Day) (Year)

(c) Place: burial or cremation: Cave Springs Mo.

18. (a) Signature of funeral director: [Signature]

(b) Address: Sullivan Mo.

19. (a) Date received local registrar: Dec. 12-44 (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Franklin
(c) City or town: Sullivan
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 12 year: 1944 hour: 11 minute: 50 PM

21. I hereby certify that I attended the deceased from Dec 12 1944 to Dec 12 1944 that I last saw him alive on Dec 12 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Asphyxia Pulmonum Duration: 1 hour 40 min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: None Of operations _____

Of autopsy: none

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: [Signature] (M.D. or other) _____ Address: Sullivan Mo. Date signed: 12/12/44

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

36
4
0

1121

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-17-45

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 *Wm. P. Hoff*

Licensed Embalmer No. 7692

P. O. Address *Hullman*

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, above space should be left blank.