S. No. 2
M—2-43
. 5-17-39
P I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26193

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7776

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

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 529 Leeton St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 529 Leeton
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country: ____

3. (a) PRINT FULL NAME: Caroline Taylor

3. (b) If veteran, name war: ____

3. (c) Social Security No.: ____

4. Sex: Female

5. Color or race: Col.

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Walter Taylor

6. (c) Age of husband or wife if alive: 79 years

7. Birth date of deceased: March (Month) 18 (Day) 1870 (Year)

8. AGE: Years 75 | Months 5 | Days 13 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: ____

FATHER
12. Name: William Burke
13. Birthplace: Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary Woodfork
15. Birthplace: Troy (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Walter Taylor
(b) Address: 529 Leeton St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/6/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Washington Pk. Cem.

18. (a) Signature of funeral director: Ellis Fun. Home
(b) Address: 2820 Stoddard St.

19. (a) SEP 5 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1st year 1945 hour 8 minute 40 A.M.

21. I hereby certify that I attended the deceased from July 28 1945 to Sept 1 1945 that I last saw her alive on Sept 1 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Heart Disease — Duration 5 mos
Due to: Hypertension
Due to: Arterio Sclerosis
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 93 d
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): ____
(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: S. E. Moore (M. D. or other)
Address: 809 N. Jefferson Date signed Sept 1

(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, ~~only~~ .....

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

working under my personal supervision.

Signed Fulton E Culkin

Licensed Embalmer No. 4198.

P. O. Address 49½ Fountain Ave.

St Louis 13 - 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.