No. 2
2-43
17-39
X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

27824

State File No.

Registration District No. 144 Primary Registration District No. 3038 Registrar's No.

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Brookfield Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 27 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Linn 58
(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL")
(d) Street No. 325 E. Park 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME MYRTLE ALZINA TAYLOR
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced D 3
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 5 (Day) 1878 (Year)

8. AGE: Years 66 Months 11 Days 20 If less than one day hr. min.

9. Birthplace Maquon (City, town, or county) Ill 1 (State or foreign country)
10. Usual occupation
11. Industry or business Housewife
FATHER
12. Name Arthur Miller
13. Birthplace D.K. (City, town, or county) Ohio 1 (State or foreign country)
MOTHER
14. Maiden name Orletta Morse
15. Birthplace D.K. (City, town, or county) N.Y. 1 (State or foreign country)
16. (a) Informant Glenn Taylor
(b) Address Brookfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug (Month) 27 (Day) 1945 (Year)
(c) Place: burial or cremation Rose Hill
18. (a) Signature of funeral director Hill Funeral Home
(b) Address Brookfield Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1945 hour 1 minute a M.
21. I hereby certify that I attended the deceased from Aug. 16, 1945, to Aug. 25, 1945 that I last saw her alive on Aug 24, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cancer of left lung	7 mos.
Due to ✓	
Due to ✓	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓	
Of autopsy ✓ 47N	

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 2
23. Signature W. B. Simpson (M. D. or other) DO
Address Brookfield Mo Date signed 8/26/45

1400

(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, or by.....

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

working under my personal supervision.

Signed. J. Th. Blackbock

Licensed Embalmer No. 2246

P. O. Address. Brookfield 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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 184 Primary Registration District No. 3038 Registrar's No.

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Brookfield, Mo. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 27 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Linn

(c) City or town Brookfield (If outside city or town limits, write "RURAL")

(d) Street No. 325 E. Park (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Myrtle A. Taylor

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Dw

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 5 (Month) (Day) 1878 (Year)

8. AGE: Years 66 Months 11 Days 20 If less than one day hr. min.

9. Birthplace Maquon (City, town or county) Ill (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Arthur Miller
13. Birthplace (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Orletha Morse
15. Birthplace (City, town, or county) N.Y. (State or foreign country)

16. (a) Informant Glenn Taylor

(b) Address Brookfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-45 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield, Mo.

19. (a) 8-27-45 (Date received local registrar) (b) W. W. Cowan (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug 20 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 8-16, 1945, to 8-25, 1945 that I last saw him alive on 8-24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death cancer of left lung — Duration 7 mo.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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)

(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 W. B. Simpson (M. D. or other) D.O.

Address Brookfield, Mo. Date signed 8-26/45

SUPPLEMENTARY

5-27824