

FILED AUG 22 1945

State File No. _____

Registration District No. 544

Primary Registration District No. 6157

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Rural - Pine township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME KAY Taylor

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

4. Sex female 5. Color or race W 6. (a) Single, widowed, married, divorced (1)

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

7. Birth date of deceased July 18 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 10 hr. _____ min.

9. Birthplace Lampe, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Raymond Taylor
13. Birthplace Monett, Missouri
(City, town or county) (State or foreign country)
14. Maiden name Martha DeArmond
15. Birthplace Kalwata, Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Taylor
(b) Address Lampe, Mo.

17. (a) Burial (b) Date thereof July 19 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Wesley Church, Stone Co. Mo.
18. (a) Signature of general director Arthur Blosser

(b) Address Lampe, Mo

19. (a) 7-26-1945 (b) Chester D. Seavey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone
(c) City or town Lampe (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) _____

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1945 hour 12 minute A M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw him alive on July 18 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration 10 min

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 1572

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 D.C. Roberts (M. D. or other) _____
Address Barrequeville, Ark Date signed 7-26

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 6,
District File Number 845-921
Date Filed 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.....

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.