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v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3698**

FILED SEP 20 1945

Registration District No. 149 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1-DAY
In this community 18 months
years, months or days

3. (a) PRINT FULL NAME Tolbert Taylor
3. (b) If veteran, name war no
3. (c) Social Security No. 491-20-9798

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. JESSIE M. TAYLOR 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased FEBRUARY-7-1878
(Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 26 If less than one day 28 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name BUD TAYLOR

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

14. Maiden name Celia M. Edgemoor

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

16. (a) Informant MRS. JESSIE M. TAYLOR

(b) Address 1224 TROOST AVENUE

17. (a) BURIAL (b) Date thereof SEPT-5-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation APPLETON CITY MISSOURI

18. (a) Signature of funeral director D. H. Newsome

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 9-5-45 (b) Thereldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1224 Troost 8
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 5 year 1945 hour 1 minute 05 A. M.

21. I hereby certify that I attended the deceased from September 4 45 to September 5 45
that I last saw him alive on September 5 45
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 8301

Major findings: Of operations: _____
Of autopsy: see above
COLOUGH

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 Clark W. Seely (Name, title, or other) Med. Dir. K.C. General Hospital
Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

H. C. Newcomer Jr.

Licensed Embalmer No.

4043

P. O. Address

H. C. 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.