

FILED OCT 18 1945

Registration District No. _____

Primary Registration District No. 3012

Registrar's No. 120

1. PLACE OF DEATH:
 (a) County Clay
 (b) City or town Excelsior Springs, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 mos., 12 days
(Specify whether years, months or days)
 In this community 3 mos., 12 days

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. 219 No. Channing
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Frank M. Taylor
 3. (b) If veteran, name war World War II
 3. (c) Social Security No. 492-16-4155

4. Sex Male 5. Color or race Colored
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Wife, Beatrice Taylor
 6. (c) Age of husband or wife if alive 25 years
 7. Birth date of deceased May 6 1904
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>4</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Sand Blaster - Unemployed

11. Industry or business Steel Works

MOTHER { 12. Name Booker Taylor
 13. Birthplace Mississippi
(City, town, or county) (State or foreign country)
 14. Maiden name Cora Shannon
 15. Birthplace ?
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.
 (b) Address _____

17. (a) Removal (b) Date thereof 10-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Jefferson Barracks, Mo.

18. (a) Signature of funeral director: Herbert Hope
 (b) Address Excelsior Springs, Missouri

19. (a) 10/2/45 (b) Baroline Hutchings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 28
 year 1945 hour 9:15 minute A. M.

21. I hereby certify that I attended the deceased from June 16, 1945, to September 28, 1945;
 that I last saw him alive on September 28, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic far advanced, active, severe
 Duration unknown

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy NO AUTOPSY PERFORMED
 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) (c) Means of injury

23. Signature: S. NETZER, Major, M. C. (M. D. or other) M. D.
 Address _____ Date signed 9-28-45

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

1414

RECEIVED

District Health Officer No. 8,

Dist. File Number _____
Date Filed 10-17-41

NOV 23 1941

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 Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs, 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.