

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

1. PLACE OF DEATH:  
 (a) County Binn  
 (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 4 Weeks  
 In this community 4 Weeks  
 years, months or days (Specify whether)

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

3. (a) PRINT FULL NAME ANNA TAYLOR  
 3. (b) If veteran, name war. No.  
 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W  
 (b) Name of husband or wife Harrison Taylor 6. (c) Age of husband or wife if alive 46 years  
 7. Birth date of deceased June 19-1882  
 (Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 26 If less than one day min.

9. Birthplace Binn Mo  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

11. Industry or business  
 12. Name Charles Jacobi  
 13. Birthplace Germany  
 14. Maiden name Elizabeth Ann Giffinger  
 15. Birthplace Switzerland  
 (City, town, or county) (State or foreign country)

16. (a) Informant William P. Taylor  
 (b) Address St. Catharines, Mo  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-12-1946  
 (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) 1/17/46 (Date received local registrar) (b) Evelyn Kelly, Deputy (Registrar's signature)  
 1670 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 year 1946 hour 1 minute 15 P M.  
 21. I hereby certify that I attended the deceased from June 15 to Jan 15, 1946  
 that I last saw her alive on Jan 15 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the Colon 6 mos.  
 Due to  
 Due to  
 Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations  
 Of autopsy 46  
 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) (e) Means of injury  
 23. Signature W. K. Simpson (M. D. or other) DD  
 Address Brookfield Mo. Date signed 1-16-46

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed.....

*J. B. Blacklock*

Licensed Embalmer No. ....

*2246*

P. O. Address.....

*Beverfield 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.**