

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Grim-Smith Hospital & Clinic 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 night
(Specify whether in this community years, months or days) Most of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby 102

(c) City or town Clarence,
(If outside city or town limits, write "RURAL") 0

(d) Street No.
(If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME Mrs. Anna H. Taylor

3. (b) If veteran, name war:

3. (c) Social Security No. None

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive years (Day) (Year) 20 1865

7. Birth date of deceased: July (Month) 20 (Day) 1865 (Year)

8. AGE: Years Months Days If less than one day

| | | | |
|----|---|----|----------|
| 80 | 6 | 27 | hr. min. |
|----|---|----|----------|

9. Birthplace: Canton (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name William Evans

13. Birthplace Grundv Co Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Susan Evers

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

16. (a) Informant Rev. Perry Taylor

(b) Address Kirkville, Missouri

17. (a) Burial (b) Date thereof 2/21/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarence, Mo.

18. (a) Signature of funeral director D. E. Riley

(b) Address Kirkville, Mo.

19. (a) 3-3-46 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17 year 1946 hour 2:30 P.M. minute M.

21. I hereby certify that I attended the deceased from February 16, 1946, to Feb., 17, 1946, that I last saw him SR. alive on February 17, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death short from fracture of hip & recurrence Duration 7 days

Due to:

Due to:

Other conditions: ADDITIONAL SUPPLEMENTARY INFORMATION REQUISITE FOR PHYSICIAN
(Include pregnancy within 3 months of death)

Major findings: Of operations:

Of autopsy: 187

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) Accident 102

(b) Date of occurrence Feb 15, 1946

(c) Where did injury occur? Clarence Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

While at work? 0 (Specify type of place) (e) Means of injury

23. Signature W. Lambert 0 (M. D. or other)
Address Kirkville Mo Date signed 2-17-46

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

RECEIVED
District Health Officer No. 10
District File Number 3-46-505
Date Filed MAR 15 1946

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 D. E. Reley
Licensed Embalmer No. 4181
P. O. Address W. K. Kull

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.

Registration District No. **1**

Primary Registration District No. **3000**

1. PLACE OF DEATH:
(a) County **Adair**
(b) City or town **Parkville**
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

3. (a) PRINT FULL NAME **Anna H. Taylor**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** Year **1946** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death **fall in house**

4. Sex **F** 5. Color of race **W** 6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased **July 20** (Month) (Day) (Year)
8. AGE: Years **80** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

Duration _____
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. H. Taylor** (M. D. or other) **H. Taylor**
Address _____

SUPPLEMENTARY

3800 WRITE PLAINLY—USE UNFADING INK

