

FILED MAY 9 1946

Registration District No. **46** Primary Registration District No. **5568**

1. PLACE OF DEATH:
 (a) County **JACKSON Blue Jup**
 (b) City or town **INDEPENDENCE**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
8505 VAN HORN ROAD Rural.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community **60 YEARS** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON**
 (c) City or town **INDEPENDENCE Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **8505 VAN HORN ROAD**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **MRS. IDA OLIVE TAYLOR**
 3. (b) If veteran, name war **No** 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **APRIL** day **1ST**
 year **1946** hour **12** minute **50 P.** M.
21. I hereby certify that I attended the deceased from **3/30** **46**

4. Sex **FEMALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **WIDOWED**
 6. (b) Name of husband or wife **MR.** 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased **UNKNOWN**
 (Month) (Day) (Year)

that I last saw **her** alive on **3/30** 19 **46**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Cerebral Haemorrhage** 3 day

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

Due to **Arterio Sclerosis**
 Due to _____

9. Birthplace **JASPER FLORIDA**
 (City, town, or county) (State or foreign country)

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

10. Usual occupation **AT HOME**

Major findings: Of operations _____ Of autopsy **(630)**

MOTHER FATHER
 11. Industry or business _____
 12. Name **DR. JENNINS**
 13. Birthplace **FLORIDA**
 (City, town, or county) (State or foreign country)
 14. Maiden name **THOMAS**
 15. Birthplace **FLORIDA**
 (City, town, or county) (State or foreign country)

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

16. (a) Informant **Harold J. Taylor**
 (b) Address **8505 Van Horn Rd**
 17. (a) **CREMATION** (b) Date thereof **APRIL 3-1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **D.W. NEWCOMER'S SONS**

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 _____

18. (a) Signature of funeral director **D.W. Newcomer's Sons**
 (b) Address **1401-BRUSH GREEN BLVD.**
 19. (a) **Apr-12-1946** (b) _____
 (Date received local registrar) (Registrar's signature)

23. Signature **James J. Green** (M. D. or other) _____
 Address **1600 No.** Date signed _____

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

5400 H. John
3-6

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 Paul Rapp

Licensed Embalmer No. 23458

P. O. Address K.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.