

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15610**

1-5-43
5-17-39
1 X36671

Registration District No. **J2N 12 1945** Primary Registration District No. **5010** Registrar's No. **63**

1. PLACE OF DEATH:
(a) County **Andrew**
(b) City or town **Nodoway**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **39 years** (Specify whether years, months or days)
In this community **39 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **William Henry Taylor**
3. (b) If veteran, name war **none** 3. (c) Social Security No. **495-05-0025**

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Cora E. Taylor** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **March 21 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 2 4 hr. min.

9. Birthplace **Doniphan County Kansas**
(City, town, or county) (State or foreign country)
10. Usual occupation **railroad track maintenance**

11. Industry or business
12. Name **Adam Taylor**
13. Birthplace **unknown Kansas**
(City, town, or county) (State or foreign country)
14. Maiden name **Adaline Graves**
15. Birthplace **unknown Kansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Wm. H. Taylor**
(b) Address **Nodoway, Mo.**

17. (a) **burial** (b) Date thereof **5/27/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. John Reformed Cem.**

18. (a) Signature of funeral director **Deaton, Butler & Bowman**
(b) Address **St. Joseph, Mo.**
19. (a) **6-6-46** (b) **Lillian Sparks**
(Date received local Registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **25th**
year **1946** hour **7** minute **10** A. M.
21. I hereby certify that I attended the deceased from **May 18**, 19**46**, to **May 25**, 19**46**,
that I last saw him alive on **May 23**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death: **pernicious anemia** Duration **2 yrs.**

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **730**
Of operations
Of autopsy

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 **Ralph R. Kelley** (M, D. or other)
Address **Jivannak, Mo.** Date signed **5/26/46**

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

14502

JUN 18 1946

DISTRICT HEALTH OFFICE
Cameron, Mo.

MAR 3 1947

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

Frank A. Bowring

Licensed Embalmer No.

1710

P. O. Address

St Joseph 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.