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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22454

FILED JUL 15 1946

State File No. \_\_\_\_\_

Registration District No. 339

Primary Registration District No. 649

Registrar's No. 8

1. PLACE OF DEATH

(a) County Stoddard

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

(c) Name of hospital or institution none  
(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 Missouri (b) County Stoddard

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

(d) Street No. New Lisbon  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROBERT WILLIAM TAYLOR

(b) If veteran, name war none

(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29  
year 1946 hour 11 minute A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1946 to April 29 1946  
that I last saw him alive on April 25 1946  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color, or race White

6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Minnie Taylor

(c) Age of husband or wife if alive 71 years

7. Birth date of deceased January 28, 1874  
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis

Due to Senility

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 72 Months 3 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Commerce Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

Major findings of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name William Green Taylor

13. Birthplace New Illinois Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Adeline Price

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

16. (a) Informant Carl Taylor

(b) Address Gary, Indiana

17. (a) Burial (b) Date thereof May 2, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomfield Mo.

18. (a) Signature of funeral director Walter Morgan

(b) Address Advance, Mo.

19. (a) Jan 20 (b) Flora Morgan  
(Date received local registrar) (Registrar's signature)

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 Li

23. Signature E. C. Mader (M. D. or other) Dr.

Address Advance, Mo. Date signed 5-1-46

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

RECEIVED

District Health Office No. 2,

District File Number 746-815

Date Filed 7-9-46

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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.....

Clayton S. Morgan..... Registered Apprentice No.....  
working under my personal supervision.

Signed Clayton S. Morgan.....

Licensed Embalmer No. 3381

P. O. Address Lawrence, 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.