

FILED OCT 16 1946
Registration District No. 17

Primary Registration District No. 3016

Registrar's No. 230

1. PLACE OF DEATH:

(a) County Cole
(b) City or town JEFFERSON City
(c) Name of hospital or institution:
ST. MARY'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Cole 26
(c) City or town PURCELL 0
(If outside city or town limits, write "RURAL")
(d) Street No. SCRIVNER 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country none

3. (a) PRINT FULL NAME ROL TAYLOR

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive ✓ years _____

7. Birth date of deceased MARCH 16 1921
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 6 17 ✓ hr. ✓ min.

9. Birthplace MO VA
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business FARM

12. Name THOMAS TAYLOR

13. Birthplace Cole Co. Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Brown

15. Birthplace Cole Co. Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ruby James

(b) Address Eldon Mo

17. (a) BURIAL (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Robert Mays

(b) Address Eldon Mo

19. (a) 10-3-46 (b) R.G. Davis M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3
year 1946 hour 6 minute 25 A. M.

21. I hereby certify that I attended the deceased from September 30 to October 3 1946
that I last saw him alive on October 2 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Encephalitis
Acute
Influenza

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

Major findings:
Of operations _____
Of autopsy 23A

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 0

23. Signature J. B. Bruce (M. D. or other) _____
Address JEFFERSON City Date signed 10/3/46

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

~~Date Filed 10-7-46~~

~~District File Number~~

District Health Officer No. 8,

RECEIVED

EMAL B. 100

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 *Walter M. Kaye*

Licensed Embalmer No. *3998*

P. O. Address *Eldon 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.

Registration District No. 77

Primary Registration District No. 3016

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson city
(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 _____ (Specify whether)
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 Rol Taylor

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 5

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased mar 16 (Month) (Day) (Year)

8. AGE: Years 25 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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) 11-2-46 (b) R. P. Dorek M.D. (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ 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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Date signed _____

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY 3

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

MOTHER FATHER

33101