

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCIAL AND FINANCIAL RECORDS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35657

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9002**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2910 Chouteau**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

4. Sex **M** 5. Color or race **Col**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **Dead** years _____
7. Birth date of deceased **11 1 1903**
(Month) (Day) (Year)

8. AGE: Years **42** Months **43** Days **10** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Labor**

11. Industry or business _____

12. Name **Unknown**

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 **Mary Ross**

(b) Address **11030 Ohio St City**

17. (a) **Buried** (b) Date thereof **10-27-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **Sushowe**

(b) Address **2930 Dickson St.**

19. (a) **OCT 21 1946** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **17**
year **1946** hour **1** minute **XX** P. M.
21. I hereby certify that I attended the deceased from **9-30** to **10-17**, 19 **46**
that I last saw him - alive on **Oct. 17**, 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Nephrosclerosis; Malignant Hypertension**
Uremia
Duration **Undet.**

Due to _____
Due to _____

Other conditions: **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy: **No**
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 **1**

23. Signature **E. B. Williams** (M. D. or other) _____

Address **2601 N Whittier** Date signed **10/18/46**

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

00.
18
9
0

MOTHER FATHER

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 *Arthur L. Hoilliard*

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayard ave*

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.