

S. No. 2  
1-12-45  
7-5-17-39  
1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1365

FILED FEB 11 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 401

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days  
(Specify whether years, months or days)

In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 514 1/2 Main  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lewis Taylor

3. (b) If veteran, name war None

3. (c) Social Security No. 496-03-1558

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Ruth Taylor

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 22 1883  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>10</u>	<u>4</u>	hr. _____ min. _____

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

10. Usual occupation Resturant Work

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

12. Name John Taylor

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

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant L. D. Taylor

(b) Address R.R. #4 El Dorado Spgs. Mo.

17. (a) Burial (b) Date thereof 1-27-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary K.C. Kan.

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address 2332 Monitor Place K.C. Mo.

19. (a) 1-27-47 (b) St. Pauline Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 26  
year 1947 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan. 7 1947 to Jan. 26 1947  
that I last saw him alive on Jan. 26 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

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

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

Other conditions 13K  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy None

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 Wm W Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 1-27-47

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

MOTHER FATHER

