

FILED APR 29 1947

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

Registration District No. 349

Primary Registration District No. 4514

Registrar's No. 10

1. PLACE OF DEATH:  
(a) County Sullivan  
(b) City or town Green City  
(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 20 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Sullivan  
(c) City or town Green City Mo  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME MAYNARD TAYLOR  
(b) If veteran, name war V  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr day 6  
year 1947 hour 5 minute 30 P.M.  
21. I hereby certify that I attended the deceased from Mar 27 1946 to Apr 6 1947  
that I last saw him alive on Apr 6 1947  
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased: 5 (Month) 13 (Day) 1920 (Year)

Immediate cause of death Pneumonia of Lungs, Bronch  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
46 10 23 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

10. Usual occupation incapacitated

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

MOTHER FATHER  
12. Name Thomas E Taylor  
13. Birthplace Bellewith Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Jeanne Jane Green  
15. Birthplace Sullivan Co Mo  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Leah Taylor  
(b) Address Green City Mo

17. (a) Burial (b) Date thereof 4-10-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green City Cem

18. (a) Signature of funeral director Thomas E. Green  
(b) Address Green City Mo

19. (a) 4-26-47 (b) Laura Shaw  
(Date received local registrar) (Registrar's signature)

23. Signature W. Herington MD (M. D. or other)  
Address Green City Mo Date signed 4-9-47

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. \_\_\_\_\_  
District File Number - 4-47-72  
Dated - APR-28-1947

**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 Glenn E. Kent  
Licensed Embalmer No. 1769  
P. O. Address Green City

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16180

Registration District No. 349

Primary Registration District No. 4514

Registrar's No. 100

1. PLACE OF DEATH

(a) County Sullivan  
(b) City or town Green 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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME

Maynard 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 S

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

7. Birth date of deceased May 13 1949  
(Month) (Day) (Year)

8. AGE: Years 46 Months 13 Days 3 (if less than one day hr. min.)

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

15. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 19 Year 1949  
Hour \_\_\_\_\_ minute 30 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_  
that I last saw her alive on March 27, 1949  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia  
Duration 11 days

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) Means of injury \_\_\_\_\_

23. Signature W. H. ... MD (M. D. or other)

Address Green City MO Date signed 5-9-49

SUPPLEMENTARY

