#14230

. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36318

FILED NOV 7 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10074

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis,Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St.Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 hours (Specify whether

In this community newborn
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-0-0

(c) City or town St.Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1321 S. Broadway 9
(If rural, give location)

Memorial 23 d

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

If yes, name country

3. (a) PRINT FULL NAME Baby Boy Taylor #2

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased October 18th,1947
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 9 hr. min.

9. Birthplace St.Louis City Hospital 0
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name August Taylor
13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Tessie Isgriggs
15. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant M.Renard
(b) Address St.Louis City Hospital.

17. (a) Anatomical Board (b) Date thereof 10-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, O.

18. (a) Signature of funeral director [illegible]

(b) Address 3500 Reeves St

19. (a) OCT 31 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18th
year 1947 hour 11:30 minute P M.

21. I hereby certify that I attended the deceased from 10/18/47
, 19, to Oct. 18th, 1947
that I last saw him alive on Oct. 18th, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature W. J. Kennedy (M. D. or other)

Address 1515 Lafayette Date signed 10/21/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.