

S. No. 2
M-5-43
5-17-39
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41433

State File No. _____

FILED JAN 8 1948
128

Registration District No. _____

Primary Registration District No. **2000**

Registrar's No. **1084**

1. PLACE OF DEATH:

(c) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **16 hrs**
In this community **16 hrs**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Dallas**
(c) City or town **Red Top Rural**
(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 **Taylor, Baby Boy - not named**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **m.** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **G**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 12 1947**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **18 hr.** min. _____

9. Birthplace **Red Top Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name **Frank A. Taylor**
13. Birthplace **Bakersfield Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Jewell Newman**
15. Birthplace **Chority Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Taylor**
(b) Address **Red Top Mo.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec 14 1947**
(Month) (Day) (Year)
(c) Place: burial or cremation **Oliver Cemetery**

18. (a) Signature of funeral director **Body was taken**
(b) Address **by relatives to Red Top Mo. for**
12-14-47 (Date received local registrar) (b) **WE [Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **13**
year **1947** hour **5** minute **P.** M.

21. I hereby certify that I attended the deceased from **12-13**, 19 **47**, to **12-13**, 19 **47**
that I last saw **him** alive on **12-13**, 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Premature Birth**
Due to _____
Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations **159**
Of autopsy _____
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)
(c) Means of injury **0**
23. Signature **Neil Bussell** (M. D. or other) _____
Address **Springfield Mo.** Date signed **12-16-47**

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

39
2
11
0

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.