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. 42447

FILED DEC 31 1947

Registration District No. 8517

Primary Registration District No. 8517

Registrar's No. 9

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

1. PLACE OF DEATH:

(a) County Morgan

(b) City or town Syracuse Mo. (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 ..... In this community Nine years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Morgan

(c) City or town Syracuse (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 Native

3. (a) PRINT FULL NAME EMMA S. TAYLOR

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Henderson W. Taylor

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased June (Month) 27 (Day) 1899 (Year)

8. AGE: Years 57 Months 5 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace Smithton (City, town, or county) Mo (State or foreign country) O

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER

12. Name Harry Wlaunt

13. Birthplace St Charles (City, town, or county) Mo (State or foreign country) O

14. Maiden name Lizzie Burgomaster

15. Birthplace St Charles (City, town, or county) Mo (State or foreign country) O

16. (a) Informant W. T. Taylor

(b) Address Syracuse Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Smithton Mo

18. (a) Signature of funeral director Jewell E. Richards

(b) Address Sedalia Mo

19. (a) 12/27/47 (Date received by local registrar) (b) Myrta Hutsinpillar (Registrar's signature) 913

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1947 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from Last / 1930 to Dec 22 1947 that I last saw h..... alive on ..... 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Asthma	20 yrs
Due to: Hypertensive Heart Disease	10 yrs
Due to: Right side paralyzed	7 yrs
Due to: Fracture of Hip Shoulder	3 wks
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN (Underline the cause of death which 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 11

(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 6

23. Signature Todd L. Fogle (M. D. or other) M.D.

Address Otterville Mo Date signed 12-26-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 James E. Richards

Licensed Embalmer No. 2466

P. O. Address Tipton Mo

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.

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3-45
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan 9

Registration District No. 25 Primary Registration District No. 8517 Registrar's No.

1. PLACE OF DEATH:
(a) County Morgan
(b) City or town Syracuse
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Emma S. Taylor
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive

7. Birth date of deceased June 27 1887
(Month) (Day) (Year)

8. AGE: Years 57 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or Business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1942 hour p.m. minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Right-side paralysis 7 yrs. Hip broken

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) accident fall
(b) Date of occurrence November 17-1942
(c) Where did injury occur? Syracuse (City or town) (County) (State) Mo
(d) Did injury occur in or about home, on farm, in industrial place, in public place? House. Walking to telephone (Specify type of place)
While at work? no (e) Means of injury

23. Signature Robt L. Fogle (M. D. or other) MD
Address Otterville Mo Date signed 1/10 1943

42447