

FILED JUN 26 1948

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 499

1. PLACE OF DEATH:

(a) 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: St. Johns Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 1/2 hrs.  
In this community 2 1/2 hrs.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1863 N. Main  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Don Wayne Taylor

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 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 June 15, 1948  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 0 7 hr. 30 min.

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

10. Usual occupation Infant

11. Industry or business Infant

MOTHER FATHER { 12. Name Ralph Wayne Taylor

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

14. Maiden name Walsie Oshelia Hawkins

15. Birthplace South Fork Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Taylor  
(b) Address 1863 N. Main

17. (a) Burial (b) Date thereof 6-16-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Comfort

18. (a) Signature of funeral director J. W. Klingner & Co.  
(b) Address Springfield Mo.

19. (a) 6-16-48 (b) N. E. Audley MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15  
year 1948 hour 2:00 minute PM

21. I hereby certify that I attended the deceased from 6:45 PM  
June 15, 1948, to 2:00 PM 6-15-48, 1948  
that I last saw him alive on 6-15-48, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary atelectasis  
Duration \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 1/6/48  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(e) Mechanism of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Springfield Mo. Date signed 6-15-48

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

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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.

*Not Embalmed*

Signed *Ogle Stone Jr.*

Licensed Embalmer No. *4174*

P. O. Address *Springfield 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.**