

No. 300  
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5-17-39  
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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40382

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

FILED JAN 15 1949  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5276

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Hospital # 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)  
In this community no 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Scotts Bluff, Nebr.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1510 1st Ave.,  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Alfred D. Taylor

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

4. Sex Male 5. Color or race wh 6. (a) Single, widowed, married, divorced Div. 3  
6. (b) Name of husband or wife Eva Herr 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 2/25/1879  
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Carpenter

11. Industry or business --

12. Name Robert Taylor

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

14. Maiden name Mary Ellen Warnerick

15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lucy Lytle

(b) Address Gashland, Mo.

17. (a) Burial (b) Date thereof Removal 12/27/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mayville, Mo.

18. (a) Signature of funeral director John P. Shell

(b) Address Kansas City, Mo.

19. (a) 12-27-48 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23  
year 1948 hour 11<sup>00</sup> minute P M.

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

Immediate cause of death Basal skull fracture  
Duration \_\_\_\_\_

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

Due to Auto + truck

Other conditions suppura on leg  
(Include pregnancy within 3 months of death)

Major findings of operations REQUESTED 170C-8

Of autopsy no  
History & Inspection

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident?

(b) Date of occurrence 12-23-48  
Where did injury occur? day no

(c) Place: burial or cremation public place  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (e) Means of injury auto truck

23. Signature James C. Walker (M. D. or other) Coram

Address 1424 W. 1st St Date signed 12-24-48

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

14  
3  
8

✓

MOTHER FATHER

Dec

12-2

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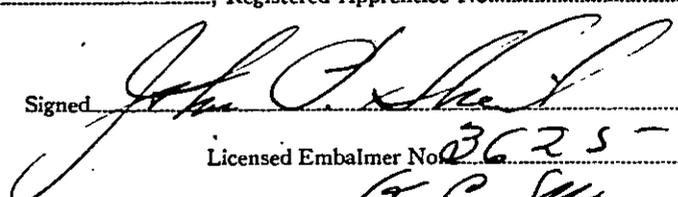
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**STATEMENT BY LICENSED EMBALMER**

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.

Signed



Licensed Embalmer No. 3625-

P. O. Address R. C. Shea

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4.0382-98  
Registrar's No. 5276

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(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 2 days  
Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME alfred D. Taylor

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

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

9. Birthplace..... (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) (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) 12-27-48 (b) Seraldine Holmes  
(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 Dec Day.....  
year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw him/her alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: 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 12-21-48

(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.....

Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

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

