

FILED FEB 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1443
191

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON MO.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (In this place) 38 YRS.		d. STREET ADDRESS (If rural, give location) 4017 BELL STREET	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4017 BELL STREET			

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) PAXTON c. (Last) TAYLOR			4. DATE OF DEATH (Month) (Day) (Year) JANUARY 13, 1949		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED 5	
8. DATE OF BIRTH MAY 29, 1910		9. AGE (In years last birthday) 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 9 YEARS	
11. BIRTHPLACE (State or foreign country) KANSAS CITY MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME JOHN TAYLOR		13b. MOTHER'S MAIDEN NAME MAYME HERRON		14. NAME OF HUSBAND OR WIFE MRS. JOSEPHINE TAYLOR	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 490-01-0055		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOHN TAYLOR - 4017 BELL STREET, K.C. MO.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 9 YRS ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) - DUE TO (c) - II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. - 345			
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19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 0	

22. I hereby certify that I attended the deceased from 1940 to 13 Jan, 1949, that I last saw the deceased alive on 20 Dec, 1948, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE F. H. Wakefield (Degree or title) F. H. Wakefield M.D.		23b. ADDRESS 1102 Grand Ave K.C. Mo		23c. DATE SIGNED 14 Jan 49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JAN 15 1949		24c. NAME OF CEMETERY OR CREMATORY MT. MORIAN CEMETERY	
				24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI	

DATE REC'D BY LOCAL REG. 1-15-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1401 BRUSH CREEK BL'VD. KANSAS CITY, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1:30-4:80

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed *A. D. Noflinger*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *3438*

P. O. Address *Kansas City*

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.