

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4260

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

BIRTH NO. _____		REG. DIST. NO. <u>55</u>		PRIMARY REG. DIST. NO. <u>304</u>		Registrar's No. <u>17</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Carroll</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Carroll</u>		admission) <u>17</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cannelton</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cannelton</u>		1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>417 West Lincoln</u>				d. STREET ADDRESS (If rural, give location) <u>417 West Lincoln</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) <u>TAYLOR</u>		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 21, 1949</u>	
Premature child had not been named.							
5. SEX <u>Male Negro</u>		6. COLOR OR RACE <u>Child 1</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>Feb. 20, 1949</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Cannelton Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Taylor</u>			13b. MOTHER'S MAIDEN NAME <u>Bessie Herndon</u>			14. NAME OF HUSBAND OR WIFE <u>Samuel Taylor Child</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Samuel Taylor, 417 W. Lincoln (Cannelton)</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature (22 to 24 weeks) gestation</u>					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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. <u>(Hypospadias) 976X</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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?			
22. I hereby certify that I attended the deceased from <u>Feb 20, 1949</u> , to <u>Feb 21, 1949</u> , that I last saw the deceased alive on <u>Feb 20, 1949</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (In blue or black ink) <u>Carl H Reed M.D.</u>			23b. ADDRESS <u>Carrollton, Mo.</u>			23c. DATE SIGNED <u>2-21-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/21/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>African Methodist Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Carrollton Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2/22/49</u>		REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall Funeral Home</u>		ADDRESS <u>Carrollton Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.4817  
1

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 3-10-49

*This child was not embalmed and burial was made a day later*

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.

Student \_\_\_\_\_  
Student Embalmer

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.