

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15441**
Registrar's No. _____

FILED MAY 6 1949

BIRTH NO. _____ REG. DIST. NO. **103** PRIMARY REG. DIST. NO. **5417**

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE Mo. b. COUNTY Dunklin	
b. CITY OR TOWN Holland	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Holland	3. d. STREET ADDRESS (If rural, give location) J
d. FULL NAME OF HOSPITAL OR INSTITUTION Leland			

3. NAME OF DECEASED (Type or Print) a. (First) Leroy b. (Middle) c. (Last) Taylor			4. DATE OF DEATH (Month) (Day) (Year) 4 24 49		
5. SEX m. 2 - Cal.	6. COLOR OR RACE 1	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6-4-45		9. AGE (In years last birthday) 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Herrondale Mo.	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME Comroy Taylor		13b. MOTHER'S MAIDEN NAME Aldonia Ellis		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Aldonia Taylor Herrondale Mo.		

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Burnt up in home			INTERVAL BETWEEN ONSET AND 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)			DUE TO (c)
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			DUE TO (c)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 24 m., from the causes and on the date stated above.					

23a. SIGNATURE Walter A. Hauf (Degree or title)		23b. ADDRESS Herrondale Mo		23c. DATE SIGNED 4-25-49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-24-49		24c. NAME OF CEMETERY OR CREMATORY Carr	
		24d. LOCATION (City, town, or county) (State) Blytheville Ark.			

DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE 86		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ernest Carter Blytheville, Ark.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10/10

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

Ed. R. Stovall

Signed.....

Student Embalmer

Licensed Embalmer No. *3100*

P. O. Address *Blytheville*

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.