

FILED JUL 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21765  
State File No. 5613  
Registrar's No.

318

1003

1. PLACE OF DEATH a. COUNTY -		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY 977	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Matteson 11	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,		d. STREET ADDRESS (If rural, give location) W.R. 2	
3. NAME OF DECEASED (Type or Print) a. (First) WANDA LEE b. (Middle) LEE c. (Last) TAYLOR			4. DATE OF DEATH (Month) (Day) (Year) 6 - 27 - 1949
5. SEX F /	6. COLOR OR RACE WHITE	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) /	8. DATE OF BIRTH 12-27-1930
9. AGE (In years last birthday) 18		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) me	11. BIRTHPLACE (State or foreign country) Charleston, Ill /
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Finis Taylor		13b. MOTHER'S MAIDEN NAME Mabel Stillions	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Finis Taylor ADDRESS Matteson Ill
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, ashenia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hydrocephalus DUE TO (c) E. Coli  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  INTERVAL BETWEEN ONSET AND DEATH Since birth			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) 1570
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 752X
22. I hereby certify that I attended the deceased from May 24, 1949, to June 27, 1949, that I last saw the deceased alive on June 27, 1949, and that death occurred at 12:45 p.m., from the causes and on the date stated above.			
23a. SIGNATURE F.R. Bradley (Degree or title) M.D.		23b. ADDRESS Barnes Hospital.	23c. DATE SIGNED 6/27/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-27-49	24c. NAME OF CEMETERY OR CREMATORY Charleston Ill
DATE REC'D BY LOCAL REG. JUN 29 1949		REGISTRAR'S SIGNATURE J. B. Lassiter	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service ADDRESS

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

5613

**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

*Van M Sizemore*

Licensed Embalmer No. *4343*

P. O. Address

*St Louis 10 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.