

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32253**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002** Registrar's No. **8400**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home T. Phillips		d. STREET ADDRESS (If rural, give location) 4854 Cote Brillante	

3. NAME OF DECEASED (Type or Print) a. (First) Pearl b. (Middle) R c. (Last) Taylor			4. DATE OF DEATH (Month) (Day) (Year) Sept 27, 1949		
5. SEX M	6. COLOR OF RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug 3, 1893	9. AGE (In years last birthday) MONTHS DAYS HOURS MIN. 56	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY M.O.P. railroad		11. BIRTH PLACE (State or foreign country) Ga.	

13a. FATHER'S NAME Edward Taylor		13b. MOTHER'S MAIDEN NAME Ora Smith		14. NAME OF HUSBAND OR WIFE Elizabeth Taylor	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elizabeth Taylor 4854 Cote Brillante	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO rise to the above cause (a) stating the underlying cause last. DUE TO (c)		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

Pulmonary Oedema
Arthritis
Cardiac Hypertrophy

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) 950	
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? 4343	

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 **5:10 A M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walter P. Clark		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 9/29/49	
24a. BURIAL CEMETERY, TOWN, REMOVAL (Specify) Burial		24b. DATE Oct 31, 49		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem	
24d. LOCATION (City, town, or county) ST. LOUIS		24e. (State) MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. A. Hear 4214 Delmar	

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

1621

X

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 F. C. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.