

STANDARD CERTIFICATE OF DEATH

FILED FEB 10 1951

State File No. ....

BIRTH NO. 2200-51 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 278

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>12 hr 51 m</u>		d. STREET ADDRESS (If rural, give location) <u>5541 Wabash 380</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>			
3. NAME OF DECEASED a. (First) <u>Tod</u> b. (Middle) <u>Taylor</u> c. (Last) <u>Taylor</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1-11-1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>01-10-1951</u>
9. AGE (In years last birthday)	10. MONTHS	11. DAYS	12. IF UNDER 24 HRS. Hours Min. <u>12 51</u>
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) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Henry Taylor</u>	13b. MOTHER'S MAIDEN NAME <u>Rosalie Ardew Green</u>	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 <u>Mrs William Taylor K.C. Mo.</u> ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Pneumonia rupture membranes</u> DUE TO (c) <u>(3 weeks)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>70-75</u>
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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>1-10</u> , 19 <u>51</u> , to <u>1-11</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1-11</u> , 19 <u>51</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE OF REGISTRAR <u>[Signature]</u> (Degree of title)		23b. ADDRESS <u>0620 Prof Bldg</u>	23c. DATE SIGNED <u>1-12-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>21-11-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Research Hospital</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
DATE REC'D BY LOCAL REG. <u>1-19-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Research Hosp. K.C. Mo.</u>	

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

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....  
Student Embalmer

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.