

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1951

State File No. _____
Registrar's No. 566-A

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

396

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Barry	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Rural, Seligman	0050
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) Rural Route	

3. NAME OF DECEASED (Type or Print) Wilfred	a. (First)	b. (Middle) Wellman	c. (Last) Taylor	4. DATE OF DEATH 6-24-1951	(Month)	(Day)	(Year)
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 5-16-1897	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Belt Man	10b. KIND OF BUSINESS OR INDUSTRY Campbell Soup	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Harry Taylor	13b. MOTHER'S MAIDEN NAME Marie Wellman	14. NAME OF HUSBAND OR WIFE Fern Taylor
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW I	16. SOCIAL SECURITY 319-05-5510	17. INFORMANT'S SIGNATURE OR NAME Mrs. Fern Taylor-Seligman, Missouri	ADDRESS
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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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Rheumatic heart disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 2 months many years.
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 416X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 6-23, 1951, to 6-24, 1951, that I last saw the deceased alive on 6-23, 1951, and that death occurred at 7 a m., from the causes and on the date stated above.

23a. SIGNATURE Romer Marshall, M.D.	(Degree or title)	23b. ADDRESS Professional Bldg	23c. DATE SIGNED 6-25-51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6-27-1951	24c. NAME OF CEMETERY OR CREMATORY UNKNOWN	24d. LOCATION (City, town, or county) (State) Chicago, Illinois
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DATE REC'D BY LOCAL REG. 7-2-51	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Williams	ADDRESS Cassville 7728
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TEST 02 700F

AUG 1 1952

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.....
Student Embalmer

Signed W. D. Williams

Licensed Embalmer No. 4651

P. O. Address Cassville, 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.