

no. 300  
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FILED AUG 7 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
318

25377  
State File No. 6521  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
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 St. Louis 2259	
c. LENGTH OF STAY (In this place)		d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 1117 Pine St. Apt. 204	

3. NAME OF DECEASED (Type or Print) FRANK	a. (First)	b. (Middle) M.	c. (Last) TAYLOR	4. DATE OF DEATH JULY 20 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 2, 1869	9. AGE (In years last birthday) 81	10. MONTHS	11. DAYS	12. HOURS	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Moeres Vineyard Ind.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME James C. Taylor	13b. MOTHER'S MAIDEN NAME Myra	14. NAME OF HUSBAND OR WIFE Dora
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jessie L. Garrett 3503 Miami St.
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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		INTERVAL BETWEEN ONSET AND DEATH 12 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Hypertensive cardiovascular disease yrs		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X
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22. I hereby certify that I attended the deceased from 7-9-51, 19\_\_, to 7-20-51, 19\_\_, that I last saw the deceased alive on 7-20-51, 19\_\_, and that death occurred at 6:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE John T. Lawton (Degree or title) M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 7-21-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/22/51	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Columbus, Indiana.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 21 1951 J. B. Lawton	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Amos Wedgale 3634 Gravois Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 \_\_\_\_\_

*Frank J. Dyland, Jr.*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*2675  
St. Louis*

(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.