

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39807**
Registrar's No. **10597**

FILED DEC 8- 1951

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		f. STREET ADDRESS (If rural, give location) 4039a Maffitt	

3. NAME OF DECEASED (Type or Print) a. (First) Annie b. (Middle) Taylor c. (Last) Taylor			4. DATE OF DEATH (Month) (Day) (Year) Nov. 25 1951		
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1	8. DATE OF BIRTH March 21, 1886	9. AGE (In years last birthday) 65	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Starksville, Mississippi /	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Zack Hampton	13b. MOTHER'S MAIDEN NAME Ella Williams	14. NAME OF HUSBAND OR WIFE Lincoln 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) No	16. SOCIAL SECURITY NO. 494-36-2856	17. INFORMANT'S SIGNATURE OR NAME Annie Mae Taylor	ADDRESS 4039 Maffitt
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 7 days Undet. 11
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Hypertension		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 324X
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22. I hereby certify that I attended the deceased from **11-18**, 19**51**, to **11-25**, 19**51**, that I last saw the deceased alive on **11-25**, 19**51** and that death occurred at **8:55 am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lorena W. Harris M. D.D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 11-26-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 4	24b. DATE Dec. 1, 1951	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. NOV 28 1951	REGISTRAR'S SIGNATURE J Paul Smith	25. FUNERAL DIRECTOR'S SIGNATURE L. B. Koone	ADDRESS 1221 N. Grand
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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

Laurenne Brown

Licensed Embalmer No. *4755*

P. O. Address *1221 N. Grand*

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.