

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33483

State File No.

FILED SEP 25 1952

318

1003

8093

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

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

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) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
c. LENGTH OF STAY (In this place)		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1109^a N. 23rd ST.		d. STREET ADDRESS (If rural, give location) 21 1109^a N. 23rd ST.	
3. NAME OF DECEASED (Type or Print) a. (First) SOPHIA b. (Middle) c. (Last) TAYLOR		4. DATE OF DEATH (Month) (Day) (Year) 8. 22 1952	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH APRIL 2, 1872
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months 4 Days 20	11. IF UNDER 18 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) COLUMBUS, KENTUCKY
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME JACK WALKER	
13b. MOTHER'S MAIDEN NAME IRENE ?		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Dottie Adams		ADDRESS 2905	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Endocarditis DUE TO (c) Atherosclerosis 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"/>			
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 4214	
22. I hereby certify that I attended the deceased from May 25, 1952 , to Aug 22, 1952 , that I last saw the deceased alive on Aug 21, 1952 , and that death occurred at 3:30 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE D. Jones M.D.		23b. ADDRESS 2330 Franklin Ave	
23c. DATE SIGNED 8/25/52			
24a. BURIAL, CREMATION, REMOVAL	24b. DATE 8-27-52	24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO
DATE RECD BY LOCAL REG. AUG 26 1952	REGISTRAR'S SIGNATURE J. Calver Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON	
		ADDRESS 2707 STODDARD ST.	

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 Arthur P. Heilbard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldene

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.