

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12402

State File No. _____

2506

FILED MAR 24 1953

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. _____

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS 1353 N Leffingwell		0	
3. NAME OF DECEASED (Type or Print) Julia		a. (First)		b. (Middle)	
		c. (Last) Taylor		4. DATE OF DEATH (Month) (Day) (Year) Feb. 28 1953	
5. SEX 3 Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 0	
8. DATE OF BIRTH March 10, 1900		9. AGE (In years last birthday) 52		10. UNDER 1 YEAR 11. UNDER 12 HRS.	
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) Mississippi	
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME Vince Taylor		13b. MOTHER'S MAIDEN NAME Salina Welch	
14. NAME OF HUSBAND OR WIFE None		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 V. A. Gooby, son,		ADDRESS 1353 N Leffingwell			
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) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		INTERVAL BETWEEN ONSET AND DEATH Undet.	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443X	
22. I hereby certify that I attended the deceased from 2-7, 1953 to 2-28, 1953, that I last saw the deceased alive on 2-28, 1953, and that death occurred at 5:40 P.M., from the causes and on the date stated above.					
23a. SIGNATURE Edward B Williams M. D.		(Degree or title)		23b. ADDRESS 2601 N Whittier St.	
23c. DATE SIGNED 3-3-53		24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 3-7-53	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. MAR 6 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John Allen 4214 Edman	

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

My tag!

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

F. A. Geer

Licensed Embalmer No. *2963*

P. O. Address *4214 Delaware*

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.