

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3341  
State File No. 0882

BIRTH NO. FILED FEB 4 1954 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 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4362 West Belle Place		d. STREET ADDRESS (If rural, give location) 4362 West Belle Place	

3. NAME OF DECEASED (Type or Print) Mable Taylor			4. DATE OF DEATH (Month) (Day) (Year) Jan. 25, 1954			
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 23, 1871	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 11 Days 2	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (City and State or Foreign Country) Cincinnati, Ohio 0		12. COUNTRY OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Robert Mays	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Benjamin Taylor
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Benjamin Taylor. 4362 W. Belle Pl.	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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchiectasis		INTERVAL BETWEEN ONSET AND DEATH don't know	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.		Pulmonary Hemorrhage		few minutes	

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)
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? 526X

22. I hereby certify that I attended the deceased from 9-8-53, 19, to 1-25-54, 19, that I last saw the deceased alive on 1-24-54, 19, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE Walter H. Soeismann, M.D. (Degree or title)	23b. ADDRESS 1515 St. Louis	23c. DATE SIGNED 1-27--54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/29/54	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery
		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 28 1954 J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles J. Gates, 4107 Finney Ave.
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C.P. (Licensed Embalmer's Statement on Reverse Side)

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 Arthur L. Holliday

Licensed Embalmer No. 4221

P. O. Address 4107 Tenney

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.