

FILED JUL 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21640**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **14229**

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Glendale</b>  |  | c. CITY OR TOWN <b>Glendale</b> <b>4651</b>   |  |
| c. LENGTH OF STAY (in this place) <b>19 Years</b>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>             |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Oakland Park Hospital</b> |  | e. STREET ADDRESS (If rural, give location) <b>1027 E. Essex Ave,</b>   |  |

|                                     |                         |                           |                         |   |
|-------------------------------------|-------------------------|---------------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Susan</b> | b. (Middle) <b>Shelby</b> | c. (Last) <b>Taylor</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>June 19 1954</b> |
|-------------------------------------|-------------------------|---------------------------|-------------------------|---|

|                      |                               |  |                                      |   |                                 |                                 |
|----------------------|-------------------------------|--|--------------------------------------|---|---------------------------------|---------------------------------|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b> | 8. DATE OF BIRTH <b>Oct. 16 1883</b> | 9. AGE (In years last birthday) <b>70</b> | IF UNDER 1 YEAR <b>8</b> Months | IF UNDER 24 HRS. <b>3</b> Hours |
|----------------------|-------------------------------|--|--------------------------------------|---|---------------------------------|---------------------------------|

|   |  |  |   |
|---|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Educational</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b> | 12. CITIZEN OF WHAT COUNTRY? <b>America</b> |
|---|--|--|---|

|   |   |   |
|---|---|---|
| 13a. FATHER'S NAME <b>George Taylor</b> | 13b. MOTHER'S MAIDEN NAME <b>Janie McGaffin</b> | 14. NAME OF HUSBAND OR WIFE <b>None</b> |
|---|---|---|

|  |  |  |         |
|--|--|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Oakland Park Hospital Records</b> | ADDRESS |
|--|--|--|---------|

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>   |  | unknown                                       |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerosis</b> |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>1) Tuberculosis, pulmonary advanced 20 yrs</b><br><b>2) Psychosis idiopathic 40 years.</b> |   |  |   |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? <b>332XA</b> 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) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **Jan 1947**, to **June 19, 1954**, that I last saw the deceased alive on **June 18, 1954**, and that death occurred at **2 A** m., from the causes and on the date stated above.

|   |  |                                 |
|---|--|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>Lewis Littmann M.D.</b> | 23b. ADDRESS <b>8231 Clayton Rd 67</b> | 23c. DATE SIGNED <b>6/19/54</b> |
|---|--|---------------------------------|

|  |                          |  |   |
|--|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE <b>6-21-54</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Belfontaine Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b> |
|--|--------------------------|--|---|

|   |  |  |                                |
|---|--|--|--------------------------------|
| DATE REC'D BY LOCAL REG. <b>6/19/54</b> | REGISTRAR'S SIGNATURE <b>Robert P. ...</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Meyer-Pfitzinger</b> | ADDRESS <b>Kirkwood 22 Mo.</b> |
|---|--|--|--------------------------------|

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.....  
Signature of Student Embalmer

Signed *William H. Fitzgerald*

Licensed Embalmer No. *431*

P. O. Address *Kirkwood*

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.