

STANDARD CERTIFICATE OF DEATH

BIRTH NO. 34132-54 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1330

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 Normandy		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 33-days		e. STREET ADDRESS (If rural, give location) 4131a Laclede Ave. 2197	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) ALLEN c. (Last) TAYLOR			4. DATE OF DEATH (Month) (Day) (Year) 5 6 7 7 m 54		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 5-21-51	9. AGE (In years last birthday) 24-days	10. IF UNDER 1 YEAR Days 12
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 (City and State or Foreign Country) Normandy, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Edward Taylor		13b. MOTHER'S MAIDEN NAME. Byrd, Jacques	
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) no			
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Edward F. Taylor, 4131a Laclede Ave.			

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) Respiratory Failure ANTECEDENT CAUSES (b) Atypical Right Bronchopneumonia (c) Pre Maturity II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 48 hrs.
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) 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 5-7-54, 1954, to 6-7-54, 1954, that I last saw the deceased alive on 6-7-54, 1954, and that death occurred at 7:55 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Pickering D.D.	23b. ADDRESS 609 Natural Bridge St. Louis Mo	23c. DATE SIGNED 6-7-54
24a. BURIAL, CREMATION REMOVAL (Specify) Removal	24b. DATE June 8, 1954	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		

DATE REC'D BY LOCAL REG. 1954	REGISTRAR'S SIGNATURE Herbert R. Donnelly	FUNERAL DIRECTOR'S SIGNATURE J. Donnelly	ADDRESS 3840 Lindell Blvd.
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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 me..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed [Signature].....

Licensed Embalmer No. 4579

P. O. Address [Signature]

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.