

FILED SEP 8 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28393

BIRTH NO. _____		REG. DIST. NO. <u>244</u>		PRIMARY REG. DIST. NO. <u>5-834</u>		Registrar's No. <u>18</u>		
1. PLACE OF DEATH a. COUNTY <u>NEWTON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>NEWTON</u>				
b. CITY (If outside corporate limits, write RURAL and give OR TOWN RURAL <u>MARIONA TWSH</u>)		c. LENGTH OF STAY (in this place) <u>3 WEEKS</u>		c. CITY RURAL OR TOWN <u>MARIONA TWSH</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ROUTE 2, JOPLIN</u>				e. STREET ADDRESS (if rural, give location) <u>ROUTE 2, JOPLIN</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>			b. (Middle) <u>A.</u>		c. (Last) <u>TAYLOR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 27, 1954</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAR. 20, 1872</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMEMAKING</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>JASPER COUNTY, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>MONROE LANDRETH</u>			13b. MOTHER'S MAIDEN NAME <u>CAROLINE COGLIZER</u>		14. NAME OF HUSBAND OR WIFE <u>SAMUEL W. TAYLOR, DEC'D</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>WILLIAM TAYLOR, RT 2, JOPLIN, MO.</u>				
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) <u>Cardiac Inefficiency Valvular Lesions</u> ANTECEDENT CAUSES <u>Lesions Valvular Lesions</u> Morbidity 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.					INTERVAL BETWEEN ONSET AND 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) 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 <u>July 27, 1954</u> , to <u>Aug 13, 1954</u> , that I last saw the deceased alive on <u>Aug 13, 1954</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>John W. Douglas M.D.</u>				23b. ADDRESS <u>218 West 32nd Joplin Mo</u>		23c. DATE SIGNED <u>8/30/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8-29-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SAGINAW CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>SAGINAW, MISSOURI</u>		
DATE REC'D BY LOCAL REG. <u>Sept. 2-54</u>		REGISTRAR'S SIGNATURE <u>Mrs. Albe Parnell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STEVE PARKER MORTUARY, JOPLIN, MO.</u>		ADDRESS		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

NEWTON COUNTY HEALTH UNIT

District Health Officer No. _____

District File Number 954-186

Date Filed SEP 7 1954

NEOSHO, MISSOURI

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 F. M. Jones

Licensed Embalmer No. 231

P. O. Address Joplin

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.