

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36039

State File No.

FILED NOV 1 - 1954

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 9592

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 OR TOWN Saint Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 3855 Easton	
3. NAME OF DECEASED (Type or Print) a. (First) Minnie		b. (Middle)	c. (Last) Taylor
4. DATE OF DEATH (Month) 10 (Day) 19 (Year) 54		5. SEX Female	
6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 10-6-1903		9. AGE (In years last birthday) 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Lula, Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Oscar Henderson		13b. MOTHER'S MAIDEN NAME Narsis Scales	
14. NAME OF HUSBAND OR WIFE Virgil Taylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 500-30-6931		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Virgil Taylor 3855 Easton 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., to 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? 331X		22. I hereby certify that I attended the deceased from 10-16, 1954, to 10-19, 1954, that I last saw the deceased alive on 10-19, 1954, and that death occurred at 3:00A m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Edw. B. Williams M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 10-19-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 10-30-54		24c. NAME OF CEMETERY OR CREMATORY Washington Park cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Carl Smith, M.D. Metropolitan Funeral System, Inc. 5010 Enright	
DATE REC'D BY LOCAL REG. OCT 22 1954		REGISTRAR'S SIGNATURE	

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 *Paul Freeman*.....

Licensed Embalmer No. *4686*

P. O. Address *4729 Hamme*

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.