

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42868
Registrar's No. 10842

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003							
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. LENGTH OF STAY (In this place) 5 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2/39						
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital			d. STREET ADDRESS (If rural, give location) 5100 Arsenal St.								
3. NAME OF DECEASED (Type or Print) a. (First) NORINE b. (Middle) WEISS c. (Last) TAYLOR			4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1954								
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11/20/1889	9. AGE (In years last birthday) 65	<table border="1"> <tr> <td># UNDER 1 YEAR</td> <td># UNDER 2 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>	# UNDER 1 YEAR	# UNDER 2 HRS.	Months	Days	Hours	Min.
# UNDER 1 YEAR	# UNDER 2 HRS.										
Months	Days										
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 At home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA						
13a. FATHER'S NAME Charles Weiss		13b. MOTHER'S MAIDEN NAME Augusta Gunther		14. NAME OF HUSBAND OR WIFE Elmer A. Taylor							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Aline Kunkel, 9423 West Chester									
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, asphyxia, etc. It means the disease, injury, or complication which caused death.											
MEDICAL CERTIFICATION											
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure				INTERVAL BETWEEN ONSET AND DEATH 5 hrs.							
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Large decubiti on buttocks				6 mos.							
DUE TO (c) Generalized arteriosclerotic cardiovascular disease c myocardial degeneration				10 yrs.							
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 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201							
22. I hereby certify that I attended the deceased from Jan 1, 1954 , to Nov. 26, 1954 , that I last saw the deceased alive on Nov 28, 1954 , and that death occurred at 4:15 p.m. , from the causes and on the date stated above.											
23a. SIGNATURE Walter R. Galt, M.D. (Degree or title)			23b. ADDRESS 5400 Arsenal St.		23c. DATE SIGNED 11/27/54						
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11/29/54	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.							
DATE REC'D BY LOCAL REG. NOV 29 1954	REGISTRAR'S SIGNATURE J. C. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral 1905 Union Blvd.								

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

Warren A. Carve

Licensed Embalmer No.

353x

P. O. Address _____

(Fa

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.