

FILED MAY 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17396

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY OR TOWN <u>Marshall</u>		c. CITY OR TOWN <u>Marshall</u>	
c. LENGTH OF STAY (in this place) <u>10 YRS.</u>		0973	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home - E. West St.</u>		d. STREET ADDRESS (If rural, give location) <u>E. West</u>	
3. NAME OF DECEASED a. (First) <u>Samuel</u> b. (Middle) <u>Lawrence</u> c. (Last) <u>Taylor</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5-17-55</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 4-92</u>
9. AGE (in years) <u>63</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Ben Taylor</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Lawrence</u>	14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>U.S.I.</u>		16. SOCIAL SECURITY NO. <u>497-14-2837</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mary Taylor - Marshall, Mo.</u>		ADDRESS _____	
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, asthenia, etc. It means the disease, injury, or complication which caused death.			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>			
ANTECEDENT CAUSES Morbid 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.			
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) <u>Marshall Mo</u>	
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 _____	
22. I hereby certify that I attended the deceased from <u>April 1955</u> , to <u>May 17, 1955</u> , that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>James A. Reed M.D.</u> (Degree or title)		23b. ADDRESS <u>Marshall Mo</u>	23c. DATE SIGNED <u>5-18-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5-20-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	24d. LOCATION (City, town, or county) (State) <u>Marshall Mo</u>
DATE REC'D BY LOCAL REG. <u>5-19-55</u>	REGISTRAR'S SIGNATURE <u>Carl E. Reed Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Genet Green, Marshall Mo</u>	

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

