

FILED AUG 19 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28656**  
**113**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Sikeston</b>	c. LENGTH OF STAY (in this place) <b>2 days</b>	c. CITY OR TOWN <b>Bell City</b>	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 <b>Mo. Delta Community Hospital</b>		STREET ADDRESS (If rural, give location) <b>Route 1</b>	

3. NAME OF DECEASED (Type or Print) <b>Annie Bell Taylor</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 4 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 25, 1916</b>	9. AGE (in years last birthday) <b>39</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and State or Foreign Country) <b>Darling, Miss.</b>	

13a. FATHER'S NAME <b>Frank Townsend</b>	13b. MOTHER'S MAIDEN NAME <b>Unk.</b>	14. NAME OF HUSBAND OR WIFE <b>James Taylor</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME <b>James Taylor, Bell City, Mo.</b>	ADDRESS -----
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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		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute renal failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic glomerulonephritis</b> <b>indefinite</b>		
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 <b>592x</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Aug. 2**, 19 **55**, to **Aug. 4**, 19 **55**, that I last saw the deceased alive on **Aug. 4**, 19 **55**, and that death occurred at **7:25 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>A. S. Walter M.D.</b>	23b. ADDRESS <b>Sikeston, Missouri</b>	23c. DATE SIGNED <b>8/5/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug. 7, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>McMullen Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>McMullen, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Aug 12-55</b>	REGISTRAR'S SIGNATURE <b>Mrs. Edna Hunter 429</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>F. J. Sparks</b>	ADDRESS <b>Charleston, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DATE RECEIVED AUG 15 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 855-171

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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 Frank Sparks  
Licensed Embalmer No. 34

P. O. Address Depe Gr...

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.