

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 19 1955

State File No. **29532**

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 819

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>North Rural Campbell Twp.</u>		c. CITY OR TOWN <u>North Campbell Rural</u>	
c. LENGTH OF STAY (in this place) <u>39 days</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>Sunshine Acres Rest Home</u>		e. STREET ADDRESS (If rural, give location) <u>R.F.D. # 4, Springfield</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>JOSEPH</u>	b. (Middle) <u>JAMES</u>	c. (Last) <u>TAYLOR</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>September 13, 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>13 Feb. 1867</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hartville, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Taylor</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Cox</u>	14. NAME OF HUSBAND OR WIFE <u>Addie Taylor</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>----</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Orville Taylor, Springfield, Missouri</u>	ADDRESS <u>Springfield, Missouri</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u>		<u>3 yrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis general</u>		<u>20 yrs</u>
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 <u>4341</u>	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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Aug 1, 1955, to Sept 13, 1955 that I last saw the deceased alive on Sept 10, 1955 and that death occurred at 4:50 P.M., from the causes and on the date stated above.

23. SIGNATURE <u>Earl W. Russell M.D.</u> (Degree or title)	23a. ADDRESS <u>195 J.S. National La Springfield Mo</u>	23c. DATE SIGNED <u>9-14-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>13 Sept. 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FARLINGTON CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>FARLINGTON, KANSAS</u>
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DATE REC'D BY LOCAL REG. <u>9-16-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred C. Thome</u> ADDRESS <u>Springfield, Mo.</u>
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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 *Ralph H. Flinn*.....
Licensed Embalmer No. *3681*.....
P. O. Address *Springfield*.....

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.