

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 - 1955

State File No.

30137

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3044 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. CITY OR TOWN <u>Carrollton</u>	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3 days</u>		e. STREET ADDRESS (If rural, give location) <u>0111</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Reuben</u> b. (Middle) <u>Alexander</u> c. (Last) <u>Taylor</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 3, 1955</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 17, 1886</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR: Months <u>-</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Service</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Carroll Co - MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>George Taylor</u>	13b. MOTHER'S MAIDEN NAME <u>Laura Walker</u>	14. NAME OF HUSBAND OR WIFE <u>Mattie Smith</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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mary Ellen Taylor</u> ADDRESS <u>3310 Broadway Kansas City, Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks.</u>
	ANTECEDENT CAUSES 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. <u>Carcinoma of both Lungs 2 1/2 years</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>163X</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) (m.)	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 Sept 30, 1955, to Oct 3, 1955, that I last saw the deceased live on Oct 2, 1955, and that death occurred at 12:45 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph T. Gale M.D.</u> (Degree or title)	23b. ADDRESS <u>Chillicothe Mo</u>	23c. DATE SIGNED <u>Oct 3 - 55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-5-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Smith Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Carroll Co. Mo</u>
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DATE REC'D BY LOCAL REG. <u>10-5-55</u>	REGISTRAR'S SIGNATURE <u>Frances A Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Dickerson Funeral Home</u> ADDRESS <u>Bozard Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 18 1955

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..... *R. M. Marshall Jr.*

Licensed Embalmer No. *446*

P. O. Address *Verrill*

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.