

FILED SEP 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **31774**BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2060**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) Clayton		c. CITY OR TOWN Warson Woods ^{4 640}	
c. LENGTH OF STAY (in this place) 8 hours		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis County Hospital		STREET ADDRESS (If rural, give location) 1641 Forest View Drive	

3. NAME OF DECEASED (Type or Print) a. (First) Anthony b. (Middle) _____ c. (Last) Taylor			4. DATE OF DEATH (Month) (Day) (Year) Sept 2, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Jan. 30, 1946			9. AGE (In years last birthday) 9 IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (City and State or Foreign Country) Richmond Heights Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Paul Taylor		13b. MOTHER'S MAIDEN NAME Maybelle Kuhlmann		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Paul Taylor 1641 Forest View Drive	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture -		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Acute Brain Injury	
		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) Open		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Road		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Madison St. Louis Co, Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 2 55 m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR Automobile Accident.	

22. I hereby certify that I attended the deceased from **9-2**, 1955, to **9-2-**, 1955, that I last saw the deceased alive on **9-2**, 1955, and that death occurred at **9:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jack L. Hagadorn MD.		23b. ADDRESS 6015 Brentwood Clayton Mo		23c. DATE SIGNED 9/3/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-5-55		24c. NAME OF CEMETERY OR CREMATORY Lake Charles Park	
		24d. LOCATION (City, town, or county) (State) Wellston, Missouri			

DATE REC'D BY LOCAL REG. 9-3-55		REGISTRAR'S SIGNATURE Heber Blombe, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sturman & Sons 2504 Woodson	
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(Licensed Embalmer's Statement on Reverse Side)

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 *David E. Gibson*

Licensed Embalmer No. *34*

P. O. Address *Carrollton*

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.