

FILED NOV 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36059**
1230

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN Osborn	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 day		e. STREET ADDRESS (If rural, give location) 0022 1/1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) STELLA	b. (Middle) MARIE	c. (Last) TAYLOR	4. DATE OF DEATH (Month) (Day) (Year) NOV. 16, 1955
-------------------------------------	--------------------------	--------------------------	-------------------------	--

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 19, 1923	9. AGE (In years last birthday) 32	if UNDER 1 YEAR Months	if UNDER 24 HRS. Hours	Min.
----------------------	-------------------------------	---	--	---	------------------------	------------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	---

13a. FATHER'S NAME Floyd Gannaway	13b. MOTHER'S MAIDEN NAME Bessie Swindler	14. NAME OF HUSBAND OR WIFE Noel E. Taylor
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Noel Taylor, Osborn, Missouri	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, 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) Myocardial failure		2 mos
	ANTECEDENT CAUSES DUE TO (b) Sub-acute bacterial endocarditis with peri-carditis DUE TO (c) Following Pneumonia		3 mos
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4300	3 mos

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)
--	--	---

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 **August 19 55**, to **Nov 16 55**, that I last saw the deceased alive on **Nov 16 1955**, and that death occurred at **9:30A** m., from the causes and on the date stated above.

23a. SIGNATURE John P. Mabrey M.D. (Degree or title)	23b. ADDRESS Plattsburg, Missouri	23c. DATE SIGNED 11-17-55
---	--	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Nov 18, 1955	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Plattsburg, Mo.
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. Nov 25, 1955	REGISTRAR'S SIGNATURE Kathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE D. D. Lyon, Plattsburg, Mo.	ADDRESS
--	--	---	---------

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 Phillips E. Cox, Student Embalmer No. 518 working under my personal supervision..

Student Phillips E. Cox
Signature of Student Embalmer

Signed Danell O. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburgh

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.