

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7739

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **25**

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>New Madrid</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Sikeston</b>		c. CITY OR TOWN <b>Morehouse</b>	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) <b>10 Days</b>		STREET ADDRESS (If rural, give location) <b>01201</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Nora</b>		b. (Middle) <b>Vina</b>		c. (Last) <b>Taylor</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>2 4 1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>2-11-1897</b>	
9. AGE (In years last birthday) <b>58</b>		IF UNDER 1 YEAR Months <b>11</b>		IF UNDER 24 HRS. Days <b>23</b> Hours <b>3</b> Min.		11. BIRTHPLACE (City and State or Foreign Country) <b>Malden, Missouri</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 <b>AT HOME</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>John Coats</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ward</b>		14. NAME OF HUSBAND OR WIFE <b>Forrest Taylor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Forrest Taylor, Morehouse, Mo.</b> 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Gallbladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 month</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>155x</b>		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 **1-1**, 19**56**, to **2-4**, 19**56**, that I last saw the deceased alive on **2-4**, 19**56**, and that death occurred at **5:35 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. M. Jarno</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>Morehouse, Missouri</b>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>2-7-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City</b>	
24d. LOCATION (City, town, or county) (State) <b>BERNIE MO</b>					

DATE REC'D BY LOCAL REG. <b>2-8-56</b>		REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Welds Funeral Home - Sikeston Mo</b> ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 13 1956

FEB 20 1956

DATE RECEIVED \_\_\_\_\_

SCOTT CO. HEALTH DEPT.

CO. FILE No. 256-~~00~~ 0170

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 Raymond Crews

Licensed Embalmer No. 340

P. O. Address Scott Co.

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.