

FILED AUG 24 1956

BIRTH NO. 66212-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6832

10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. CITY OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Firmin Desloge Hospital</u>		STREET ADDRESS (If rural, give location) <u>20 2604 Elliot 6.</u>	
3. NAME OF DECEASED (Type or Print) <u>INFANT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7 20 56</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>7-20-56</u>	
9. AGE (In years last birthday) <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Bill Glen Taylor</u>		13b. MOTHER'S MAIDEN NAME <u>Edith Maxine Baker</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Edith Maxine Baker Taylor</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>prematurity</u> ANTECEDENT CAUSES <u>Placenta Previa & hemorrhage</u> DUE TO (b) <u>4 mos.</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>761.5</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <u>July 20, 1956</u> , to <u>July 20, 1956</u> , that I last saw the deceased alive on <u>July 20, 1956</u> , and that death occurred at <u>740P</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>John L. Harris MD</u> (Degree or title)		23b. ADDRESS <u>1325 E. San. Grand</u>	
23c. DATE SIGNED <u>7-21-56</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>July 23-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Smith MD</u> ADDRESS <u>Feidner Und. Co. 2223 St. Louis Av</u>	

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 Not Embalmed, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... John P. Buchholz
Licensed Embalmer No. 1674

P. O. Address 2223 S. Hwy

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.