

FILED JAN 15 1957

STANDARD CERTIFICATE OF DEATH

State File No. 43967

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 12070	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St Louis	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 3837 SULLIVAN		e. STREET ADDRESS (If rural, give location) 10703837 SULLIVAN			
3. NAME OF DECEASED (Type or Print) MRS EMMA		a. (First)	b. (Middle)	c. (Last) TAYLOR	
4. DATE OF DEATH 12-29-56		5. SEX 3 FEMALE NEGRO			
6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH 10-7-1892	
9. AGE (In years last birthday) 64		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) SPRINGFIELD, ILL.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME SAMUEL GALLOWAY		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE DECEASED	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mamie A. Howard 3837 SULLIVAN	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HYPERTENSIVE CARDIO-VASCULAR DISEASE 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. 443X			INTERVAL BETWEEN ONSET AND DEATH 1954
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 1/4/57, 1956, to 12/29, 1956, that I last saw the deceased alive on 12/29, 1956, and that death occurred at 11:35 Am., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) William H. Sessler M.D.		23b. ADDRESS 4503 Pags		23c. DATE SIGNED 12/29/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 1-3-57		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	
24d. LOCATION (City, town, or county) (State) St Louis CO. MO.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bennie Howe 3103 Washington			
DATE REC'D BY LOCAL REG. DEC 31 1956		REGISTRAR'S SIGNATURE J. Earl Smith M.D.			

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

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**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 *W. Claude Gordon*.....

Licensed Embalmer No. *34*.....

P. O. Address *4575*.....

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.