

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY - 8 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

STATE FILE NUMBER

15364

3977

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. FRANCOIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Bismarck</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Pac. Hosp.</u>			Length of stay in lb <u>29 Days</u>		d. STREET ADDRESS (If outside, give location) <u>Box 519</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>-</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1877</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pens. Mechanical Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. R.R.</u>		11. BIRTHPLACE (City and state or country) <u>IRONCO., MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>KENYARD TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES NABORS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MAE TAYLOR BISMARCK, MO.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arterio-sclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>some 1/2 year</u>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>March 25, 1957</u> to <u>April 21, 1957</u> and last saw him alive on <u>Apr. 21, 1957</u> Death occurred at <u>2:25 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Benjamin H. Ueber, M.D.</u>			22b. ADDRESS <u>Mo. Pac. Hospital - St. Louis</u>		22c. DATE SIGNED <u>April 22, 1957</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>4-21-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC</u>		23d. LOCATION (City, town, or county) (State) <u>BISMARCK, MO</u>		
24. FUNERAL DIRECTOR <u>SHIPMAN &amp; SONS BISMARCK, MO</u>			25. DATE RECD. BY LOCAL REG. <u>APR 26 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *John V. Shipman*  
Licensed Embalmer No. *488*  
P. O. Address *Bismarck*

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.