

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 31 1958

15068-58

58-009432  
STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 102

300  
-57

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE *** b. COUNTY ***	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington		c. CITY OR TOWN ***	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hosp.		d. STREET ADDRESS (If outside, give location) ***	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Debra Kay Tayloe			4. DATE OF DEATH Month Day Year March 23, 1958		
--	--	--	--	--	--

5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1958	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
---------------	------------------------	---	---------------------------------	---------------------------------	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Washington, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	-------------------------------------

13a. FATHER'S NAME Willard O. Tayloe	13b. MOTHER'S MAIDEN NAME Flora Wehrend	14. NAME OF HUSBAND OR WIFE none
---	--	-------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Willard O. Tayloe: Owensville, Mo.
--	---------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Atelectasis		INTERVAL BETWEEN ONSET AND DEATH 5 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		7625

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prematurity Compatible With Independent Existence		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	---

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.) 2.
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Owensville, Mo.	COUNTY	STATE
---	---	--	---	--------	-------

21. I attended the deceased from 3-23-58 to 3-23-58 and last saw her alive on 3-23-58 Death occurred at 2:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Paula H. ... (Degree or title)	22b. ADDRESS Owensville, Mo.	22c. DATE SIGNED 3-24-58
--	---------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3-24-1958	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) Oak Hill, Mo.
---	------------------------	---	--

24. FUNERAL DIRECTOR Michael H. Winter	ADDRESS 2174 Winter Owensville	25. DATE RECD. BY LOCAL REG. 3/25/58	26. REGISTRAR'S SIGNATURE P. ...
---	-----------------------------------	---	-------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

*NO EMBALMING*

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 *Wilford A. W. Winter* .....

Licensed Embalmer No. *3838* .....

P. O. Address *OWENSVILLE* .....

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.