

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016965

STATE FILE NUMBER

FILED MAY 14 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1250

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis City</b> ✓			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>29 Robert Koch Hospital</b>				Length of stay in <b>10 1/2 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>1608 Delmar</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>(None)</b> Last <b>Taggett</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-73</b>	9. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight handler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (City and state or country) <b>Tuskalusa, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fred Taggett</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Foster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>(?)</b>		17. INFORMANT Address <b>Records Koch Hospital, Koch, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<b>002X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)				
20c. TIME OF INJURY Hour _____ 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 <b>10-31-47</b> to <b>4-25-58</b> and last saw <sup>her</sup> him alive on <b>4-25-58</b> Death occurred at <b>11</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>H.A. Harris MD</b>				22b. ADDRESS <b>Robert Koch Hospital, Koch, Mo</b>		22c. DATE SIGNED <b>4-26-58</b>	
23a. BURIAL OR CREMATION <b>Rowland-Aker Mortuary Service</b>		23b. DATE <b>4-28-58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANATOMICAL</b>		23d. LOCATION (City and county) (State) <b>St. Louis, Mo. ANATOMICAL</b>	
24. FUNERAL DIRECTOR <b>104 Manchester Ave St. Louis 10, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>5-8-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert P. Donke M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

Use only black ink or ribbon typewrite if possible. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

4008  
00  
56

MEDICAL CERTIFICATION

---

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.