

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019410

STATE FILE NUMBER

FILED JUN 10 1958 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 214

1. PLACE OF DEATH a. COUNTY <i>St. Francois</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Francois</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Bonne Terre</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Flat River</i> 0940		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Bonne Terre Hospital</i>			Length of stay in 1b <i>Since May 2</i>			d. STREET ADDRESS (If outside, give location) <i>216 Adams St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Mr. David</i> Middle <i>Walton</i> Last <i>Taylor</i>			4. DATE OF DEATH Month <i>May</i> Day <i>30</i> Year <i>1958</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White-Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 2-1879</i>		9. AGE (In years last birthday) <i>79-4-28</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>St. Joseph Lead Co</i>		11. BIRTHPLACE (City and state or country) <i>Caton Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mr. Enoch Railback</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Allen</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>493-05-8084</i>		17. INFORMANT <i>Mrs. Leila Scott Taylor, 216 Adams St. Flat River, Mo.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular thrombosis (recurrent - 2 previous episodes)</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							332K
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arteriosclerotic heart disease, Niessler's dysentery, Post-operative gastrostomy for perforated ulcer.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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 this 18.) <i>decreased ulcer.</i>					
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 <i>May 2, 1958</i> to <i>May 30, 1958</i> and last saw him alive on <i>May 30, 1958</i> Death occurred at <i>8:20 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <i>M. J. Haw, Jr. M.D.</i>				22b. ADDRESS <i>Bonne Terre, Mo.</i>		22c. DATE SIGNED <i>6-3-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE <i>June 1-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Park View Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Farmington Mo.</i>		
24. FUNERAL DIRECTOR <i>Abri Hood, Flat River Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>June 3, 1958</i>		26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

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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

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 *Abraham Hood*.....

Licensed Embalmer No. *278*
303 Crane St.
P. O. Address *Flat River*

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.