

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027499
STATE FILE NUMBER
6877

FILED JUL 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6877

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS - MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4016 FOLSOM AVE</u>		Length of stay in lb <u>3 YEARS 2/8</u>	d. STREET ADDRESS (If outside, give location) <u>4016 FOLSOM AVE</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED - (Type or print) First Middle Last <u>JOHN PATRICK TAULT</u>			4. DATE OF DEATH Month Day Year <u>7 - 8 - 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1886</u>	
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEGRAPH OPERATOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>WESTERN UNION</u>	11. BIRTHPLACE (City and state or country) <u>FORT SMITH, ARK</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
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13a. FATHER'S NAME <u>MATTHEW TAULT</u>	13b. MOTHER'S MAIDEN NAME <u>MARY KATHERINE CONLEY</u>	14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>
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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>490-14-3667</u>	17. INFORMANT Address <u>MRS. SARAH SAUER 4016 FOLSOM AVE</u>
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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>Fracture of the Skull;</u> <u>Brain Injury.</u> E902.021		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <u>Suffered in fall from second floor</u>	
20c. TIME OF INJURY Hour Month, Day, Year p.m. <u>7 8 58</u>	<u>poised to ground below on July 8 1958.</u>	
20d. INJURY OCCURRED WHILE AT <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.) <u>18 Frame</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St Louis MO</u>

21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at 1245 P on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John M. [Signature]</u>	(Dweller or title)	22b. ADDRESS <u>1300 [Address]</u>	22c. DATE SIGNED <u>7/10/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>7-11-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MO</u>
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24. FUNERAL DIRECTOR <u>HOWARD MICHEL 5930 SOUTH WEST</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 10 58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Harvey Kable*
Licensed Embalmer No. *4596*
P. O. Address *Flouissant, M*

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.