

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006488

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 240 Primary Registration District No. 5827 Registrar's No. 3

300
1-57

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE, <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LaFont Twsp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>LaFont Twsp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mi. S. of Conran</u>		Length of stay in lb	d. STREET (If outside, give location) ADDRESS <u>1/2 mile south of Conran</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Taylor</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</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>Jan. 13 1899</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u> Hours <u></u> Min. <u></u>
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Clarksdale, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>George Taylor</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Pesta</u>		14. NAME OF HUSBAND OR WIFE <u>Verneda Taylor</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.		17. INFORMANT Address <u>Verneda Taylor-Conran, 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>Acute Gastroenteritis with Diarrhea</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fulminating Infection</u>					
DUE TO (c) <u>Obesity</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity</u>					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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></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.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>16 February 59</u> , to <u>16 February 59</u> and last saw him alive on <u>16 Feb at 6:00 P.M.</u> Death occurred at <u>12:45 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Andrew E. Painter M.D.</u> (Degree or title)			22b. ADDRESS <u>223 King St., Portageville, Mo.</u>		22c. DATE SIGNED <u>17 Feb 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Free Will Cem</u>		23d. LOCATION (City, town, or country) (State) <u>Point Pleasant, Mo.</u>
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>2-18-59</u>	26. REGISTRAR'S SIGNATURE <u>A. L. Bonds Deputy</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NEW BRUNSWICK STATE BOARD OF EMBALMERS
P. O. 8.

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 Thomas L. Ponder

Licensed Embalmer No. 3367

P. O. Address Tilbourn, W.

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.