

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015825
STATE FILE NUMBER
2 4157

FILED MAY 12 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 3507 1/2 Easton		d. STREET ADDRESS (If outside, give location) 3507 1/2 Easton	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Taylor		4. DATE OF DEATH Month Day Year April 24, 1959	
5. SEX Female ♀	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1899 Aug. 17, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Fullam Co.	11. BIRTHPLACE (City and state or country) Basket, Ky.
13a. FATHER'S NAME Albert Taylor		13b. MOTHER'S MAIDEN NAME Sallie Houston	14. NAME OF HUSBAND OR WIFE Divorced
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 709-09-9215	17. INFORMANT Address Roosevelt Taylor 5144 Kensington
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>Congestive Failure (Heart)</i> 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) 4341			INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year a.m. p.m.		ITEM 8, 9 6-8-59 DES CORRECTED BY: I. AFFIDAVIT OF Funeral Director 2. DOCUMENT Employment Record Ballman Co. 302 Ohio h-20-37	
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 _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Paul J. Simon</i>		22b. ADDRESS 710 P Corone 3 1300 Clark	22c. DATE SIGNED 4/28/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/30/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FEDERAL DIRECTOR ADDRESS <i>E. B. Kwoon</i> 1221 N. Grand		25. DATE RECD. BY LOCAL REG. APR 28 '59	26. REGISTRAR'S SIGNATURE <i>Heart Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use any standard nomenclature in their report. No symptoms with no listed. All diseases in Part I must be causally related.

70120

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 *Melvin Blackman*
Licensed Embalmer No. *3962*
P. O. Address *1221 N. 9th*

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.