

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019695  
STATE FILE NUMBER

JUN 15 1959 Registration District No. Primary Registration District No. 2 5295

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

3. NAME OF DECEASED (Type or print) First Middle Last <u>William Woodrow Taylor</u>			4. DATE OF DEATH Month Day Year <u>June 2 1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 22 1934</u>	9. AGE (In years last birthday) <u>24</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deb Shoe Co</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Making Shoes</u>	11. BIRTHPLACE (City and state or country) <u>Franklin Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Steve Taylor</u>	13b. MOTHER'S MAIDEN NAME <u>Belle Brown</u>	14. NAME OF HUSBAND OR WIFE <u>never married</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>Yes World War II</u>	16. SOCIAL SECURITY NO. <u>319-28-1053</u>	17. INFORMANT <u>Steve Taylor</u>	Address <u>St. Clair, Mo</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>Post Traumatic Nerveles of Fight</u> <u>temporal lobe with acute</u> <u>basilar subarachnoid hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>960X 33</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Following auto accident in 1956</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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, if applicable) <u>could not be ascertained.</u>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>56</u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>65</u>	20f. CITY, TOWN, OR LOCATION <u>near St Clair Mo</u>	COUNTY <u>636</u>	STATE <u></u>
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21. I attended the deceased from Death occurred at <u>2357 A</u> on the date stated above; and to the best of my knowledge, from the causes stated.	and last saw her alive on <u></u>	and last saw him alive on <u></u>
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22a. SIGNATURE <u>Raymond J. DePuy</u> (Degree or title) <u>3</u>	22b. ADDRESS <u>1300 cloud</u>	22c. DATE SIGNED <u>6/2/59</u>
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23a. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 5 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>odd Fellow Cem</u>	23d. LOCATION (City, town, or county) <u>St Clair, Mo.</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Shemard W. Kitchell</u>	ADDRESS <u>St Clair, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 2 '59</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Sherrill W. Kitchell*

Licensed Embalmer No. *3873*  
P. O. Address *H. Clair, Mo.*

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.