

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023758

STATE FILE NUMBER

FILED JUL 3 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1653

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

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>TAYLOR</u>			4. DATE OF DEATH Month <u>JUNE</u> - Day <u>18</u> - Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>MARCH 17 1919</u>		9. AGE (In years last birthday) <u>40</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>CUSHING - OKLAHOMA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>JOHN HARRIS</u>		13b. MOTHER'S MAIDEN NAME <u>GRACE ROSENGRANT</u>		14. NAME OF HUSBAND OR WIFE <u>RAY 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. <u>500-26-5886</u>	17. INFORMANT <u>Ray Taylor</u> Address <u>House Springs 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>Toxemia (UREMIA)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>BILATERAL URETERAL OBSTRUCTION OF CERVIX</u>	<u>2-3 mos.</u>
	DUE TO (c) <u>EXTENSION OF PRIMARY EPIDERMAL CARCINOMA</u>	<u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>171X</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>171X</u>	
20c. TIME OF INJURY Hour <u>9:27</u> Month, Day, Year a.m. p.m.	20f. CITY, TOWN, OR LOCATION <u>House Springs Mo</u>	
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. COUNTY <u>JEFFERSON</u> STATE <u>MO</u>

21. I attended the deceased from 7-8-58 to 6-19-59 and last saw ^{her} him alive on 6-18-59
Death occurred at 9:27 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Theodore E. Kane</u> (Degree or title) <u>D.O.</u>	22b. ADDRESS <u>High Ridge Mo.</u>	22c. DATE SIGNED <u>6-19-59</u>
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23a. RITUAL CREMATION, BURIAL, OR OTHER <u>BURIAL</u>	23b. DATE <u>JUNE 20 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL BAPTIST CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>CEDAR HILL Mo</u>
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24. FUNERAL DIRECTOR <u>Brimmer Funeral Home - House Springs Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-19-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy Md.</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 *Gustav W. Putz*

Licensed Embalmer No. *4329*
P. O. Address *St. Louis 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.