

FEDERAL BUREAU OF INVESTIGATION  
 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS AUG 17 1959

59-027276

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-7057** STATE FILE NUMBER

|  |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>                   |  |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>  |  | Length of stay in lb<br><b>10 Years</b>   |  | c. CITY OR TOWN <b>St. Louis 21</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Christian Hospital</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>10014 Monarch Drive</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Ervin</b> Last <b>Taylor, Sr</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>29</b> Year <b>1959</b>  |  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9/3/97</b>  |   |  |
| 9. AGE (last birthday)<br><b>61</b>  |  | IF UNDER 1 YEAR<br>Months _____ Days _____  |  | IF UNDER 24 HR<br>Hours _____ Min. _____  |  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Employee</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Am. Lithofold Co</b>                         |   | 11. BIRTHPLACE (City and state or country)<br><b>Alabama</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>      |  |
| 13a. FATHER'S NAME<br><b>William C. Taylor</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><del>Reynolds</del> <b>Dovie Riddle</b>                 |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Odessa C. Taylor</b>                               |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   | 16. SOCIAL SECURITY NO.<br><b>408-03-1722</b>  |   | 17. INFORMANT<br>Address<br><b>Mr John E. Taylor 10014 Monarch Dr</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Enter - Septal Myocardial infarction</b>  |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  | DUE TO (b)<br><b>420.1</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)<br><b>Coronary artery Disease</b>  |  |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>p.m. _____  |  | Month, Day, Year  |  |   |  |  |   |  |
| 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. CITY, TOWN, OR LOCATION  |  | COUNTY STATE   |   |  |
| 21. I attended the deceased from <b>7-27-59</b> to <b>7-29-59</b> and last saw him alive on <b>7-29-59</b> .<br>Death occurred at <b>12:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |   |  |
| 22a. SIGNATURE<br><b>J. E. Taylor M.D.</b> (Degree or title)   |  |   |  | 22b. ADDRESS<br><b>4110 W. Flannortau</b>   |  | 22c. DATE SIGNED<br><b>7-29-59</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>7/29/59</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Waverly, Tennessee</b>   |  | 23d. LOCATION (City, town, or county) (State)  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Luff-Bowen Waverly, Tennessee</b> ADDRESS   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 30 1959</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b>                                 |   |  |

BY AFFIDAVIT OF St. Louis Funeral Dir. DOCUMENT MEDICAL CERTIFICATION

Dr. Harvey Morris

4110 W. Florissant

Ev. 1-8824

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Joe E. McEwen

Licensed Embalmer No. 2464

P. O. Address 6143 P...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.