

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-029469

FILED VS SEP 4 1959 *50*

Registration District No. \_\_\_\_\_ Primary Registration District No. *5574* Registrar's No. *193*

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sni-Bar Twp.</b> Length of stay in 1b <b>4 days</b> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MO. 3 Mi. S.E. Grain Valley</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>6207 East 10th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Russell Stark Taylor</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>Aug. 26, 1959</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Mar. 4, 1917</b>	<b>9. AGE (last birthday)</b> <b>42</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Oil Co.</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Otterville, Mo. USA</b>			
<b>13a. FATHER'S NAME</b> <b>Charles M. Taylor</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Alma Stark</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Never Married</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>499-10-3292</b>		<b>17. INFORMANT</b> Address <b>Charles J. Taylor, Lee's Summit, Mo</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet Wound Head</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not the immediate cause (e.g., disease condition given in PART I (a)) <b>Treated at Gen Hosp favorably</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input checked="" type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (E.g., nature of injury in PART I or PART II of item 18.) <b>Apparently self-inflicted</b>			
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year <b>8:26 p.m. 8-26-59</b>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>			
<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <b>Jackson Mo</b>							
<b>21. I attended the deceased from _____ to _____ and last saw him alive on _____.</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Richard A. Owens Coroner</b>			<b>22b. ADDRESS</b> <b>1034 Rialto Bldg</b>		<b>22c. DATE SIGNED</b> <b>8-27-59</b>		
<b>23a. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>Aug. 29, 1959</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>New Lebanon Cemetery</b>			
<b>23d. LOCATION</b> (City, town, or county) <b>New Lebanon Mo.</b>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Langsford Funeral Home, Lee's Summit</b>					
<b>25. DATE RECD. BY LOCAL REG.</b> <b>Aug. 27, 1959</b>			<b>26. REGISTRAR'S SIGNATURE</b> <b>N. B. Langsford</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 D. B. Langsford

Licensed Embalmer No. 14

P. O. Address Leeds

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.