

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS OCT 19 1959**

**59-038140**

STATE FILE NUMBER

2-9201

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

MEMORIALIZED

1. PLACE OF DEATH a. COUNTY <b>None</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>None</b>		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Length of stay in lb		c. CITY OR TOWN <b>Saint Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4505 Cottage Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4505a Cottage</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Ellen TAYLOR</b>			4. DATE OF DEATH <b>October 4, 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/94</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR IF UNDER 24 HR
					Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Tennessee</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John Gilmore</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Hill</b>		14. NAME OF HUSBAND OR WIFE <b>Oscar Taylor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Barbara Light, 4505a Cottage Ave</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Breast</b>					<b>1956</b>
DUE TO (b) <b>Carcinoma of Left Breast</b>					<b>operation 1954</b>
DUE TO (c) <b>170x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days.
					<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? 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 Hour _____ a.m. _____ 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>Oct 1, 1959</b> to <b>October 4, 1959</b> and last saw her/him alive on <b>Oct. 3, 1959</b> Death occurred at <b>8:25 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>James M. Hillier</i> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>916a N. Taylor Avenue</b>		22c. DATE SIGNED <b>10-5-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/8/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>Berkeley City, Mo.</b> (State)		
24. FUNERAL DIRECTOR <b>Dunn Bros. Funeral Home, 3847 Page</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>OCT 7 '59</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*acm*

**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 Arthur L. Heilbard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave.

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.