

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS. DEC 28 1959

042

Primary Registration District No. 1000

Registrar's No. 1273

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>2 DAYS</u>		c. CITY OR TOWN <u>St Joseph</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Saint Joseph Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Huntoon Road</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lorraine Burnie Taylor</u>				4. DATE OF DEATH Month Day Year <u>12 15 - 1959</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-3-1918</u>		9. AGE (last birthday) <u>41</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee Armor meet packing CO</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CAWOOD MO</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Burnie Taylor</u>				13b. MOTHER'S MAIDEN NAME <u>Margrete Wells</u>				14. NAME OF HUSBAND OR WIFE <u>---</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>503-14-1734</u>		17. INFORMANT <u>Mrs. Margrete Taylor 218 rd 17th st mo</u>				Address <u>St. Joseph</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>Pulmonary Heart Disease</u> <u>Heart Failure</u> DUE TO (b) <u>Chronic Bronchitis &amp; Emphysema</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>6 days + 9 months</u>			
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 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 Month, Day, Year s.m. p.m.		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 <u>12-9-59</u> to <u>12-15-59</u> and last saw <sup>her</sup> him alive on <u>12-15-59</u> Death occurred at <u>8 1/2 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>H.C. Senne MD</u>						22b. ADDRESS <u>20706 BNy St. Joseph, Mo</u>			22c. DATE SIGNED <u>12-17-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-15-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH</u>		23d. LOCATION (City, town, or county) <u>SAVANNAH</u>		(State) <u>MO</u>					
24. FUNERAL DIRECTOR <u>Breit-HAWKINS Funeral Home</u>				25. DATE RECD. BY LOCAL REG. <u>Dec 18, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clara Goodell</u>							

DOCUMENT

MEDICAL CERTIFICATION  
H.C. Senne, M.D.

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*E. C. Breit*

Licensed Embalmer No. 2650

P. O. Address SAVANNAH

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.