

**FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JAN 2 2 1960**

**-60-004144**

**508** STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2**

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>2830 Stoddard Street</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>SAMUEL</b> Middle <b>PETER</b> Last <b>TAYLOR</b>			<b>4. DATE OF DEATH</b> Month <b>JANUARY</b> Day <b>13</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-13-1897</b>	<b>9. AGE (last birthday)</b> <b>62</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours _____ Min. _____ IF UNDER 24 HR 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>Packing Company</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Mississippi</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		
<b>13a. FATHER'S NAME</b> <b>William Taylor</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Adline Newton</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Mattie Taylor</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>?</b>	<b>17. INFORMANT</b> Address <b>Mattie Taylor 2830 Stoddard Street</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>BRONCHOGENIC CARCINOMA, METASTATIC TO LIVER WITH SUPERIOR VENA CAVAL OBSTRUCTION</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</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 type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>						
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____ COUNTY _____ STATE _____					
<b>21. I attended the deceased from</b> <b>DEC. 9, 1959</b> to <b>JAN. 13, 1960</b> and last saw <sup>her</sup> <del>him</del> <sup>live on</sup> <b>JAN. 13, 1960</b> Death occurred at <b>2:40 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <i>C. O. Vermillion, M.D.</i>				<b>22b. ADDRESS</b> <b>BARNES HOSPITAL</b>		<b>22c. DATE SIGNED</b> <b>1/14/60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>1-18-60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenwood Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Ellis Funeral Home, Inc. 2820 Stoddard</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>JAN 15 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

**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 Guilford E. Culkin

Licensed Embalmer No. 7498

P. O. Address Harvard

**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.