

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS APR 22 1960

**-60-017549**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1216

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>	Length of stay in 1b <u>9 hrs</u>	c. CITY OR TOWN <u>Fenton</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>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rte 2 Box 164 H</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Brian</u> Middle <u>Thomas</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>60</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 type="checkbox"/>	8. DATE OF BIRTH <u>4/9/60</u>	9. AGE (last birthday) <u>-</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	IF UNDER 24 HR Hours <u>9</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>_____</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>_____</u>		11. BIRTHPLACE (City and state or country) <u>KIRKWOOD, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>James Edward Taylor</u>		13b. MOTHER'S MAIDEN NAME <u>Charlotte Loren Phillips</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>_____</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Mr. James Taylor</u>	
				Address <u>FENTON, MI.</u>	

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 <u>9 hours</u> <u>9 hours</u> <u>9 hours</u>
IMMEDIATE CAUSE (a) <u>Hyaline Membrane disease lungs</u>			
DUE TO (b) <u>Pneumonia due to aspiration Aspiration</u>			
DUE TO (c) <u>Atelectasis Pulmonary</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Polyhydramnios Mother</u>			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.) <u>_____</u>	
20c. TIME OF INJURY Hour <u>_____</u> a.m. <u>_____</u> p.m. <u>_____</u> Month, Day, Year <u>4-9-60</u>	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.) <u>_____</u>		20f. CITY, TOWN, OR LOCATION <u>_____</u>	COUNTY <u>_____</u> STATE <u>_____</u>
21. I attended the deceased from <u>4-9-60</u> to <u>4-10-60</u> and last saw him alive on <u>4-10-60</u> Death occurred at <u>3:55 am 4/10/60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Francis J. Wenzel, M.D.</u> (Degree or title)		22b. ADDRESS <u>Featon Medical Bldg - Featon</u>		22c. DATE SIGNED <u>_____</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>_____</u>	23b. DATE <u>4-11-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pacific Cem</u>	23d. LOCATION (City, town, or county) <u>Pacific</u>	(State) <u>Mo.</u>
24. FUNERAL DIRECTOR <u>Mrs. John L. Huetter</u>		ADDRESS <u>Jacifer Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-13-60</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy</u>

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

not embalmed

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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 was not embalmed, fact should be so stated above.