

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS MAY 25 1960

=60-021605

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5127** STATE FILE NUMBER

| | | | | | | | |
|--|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Length of stay in 1b 40 YRS | | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6049 CABANNE PLACE | | | | d. STREET ADDRESS (If outside, give location) 6049 CABANNE PLACE | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last John L. L Taneyhill | | | | 4. DATE OF DEATH Month Day Year MAY 14, 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH APR. 28 1892 | 9. AGE (last birthday) 68 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) SUPERVISOR | | | 10b. KIND OF BUSINESS OR INDUSTRY SHOE CO. | | 11. BIRTHPLACE (City and state or country) WATERLOO IOWA | | 12. CITIZEN OF WHAT COUNTRY U S A |
| 13a. FATHER'S NAME OLIN B. TANEYHILL | | | 13b. MOTHER'S MAIDEN NAME EVA L KELLY | | 14. NAME OF HUSBAND OR WIFE SINGLE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Charles L. Taneyhill 6049 Cabanne P. St. Louis, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Hemorrhage</i> DUE TO (b) <i>Parkinson Disease</i> DUE TO (c) <i>350x</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| 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 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 5-8-60 to death and last saw ^{her} him alive on 5-14-60 Death occurred at 5-15-60 11-7 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Lina Kelly MD</i> | | | | 22b. ADDRESS 730 Kodiamont | | 22c. DATE SIGNED 5-15-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE May 16, 60 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Valley Cem. | | 23d. LOCATION (City, town, or county) Osage, Iowa | | (State) |
| 24. FUNERAL DIRECTOR Heiligtag Funeral Home, Imperial, Mo. | | | | 25. DATE RECD. BY LOCAL REG. MAY 16 1960 | | 26. REGISTRAR'S SIGNATURE <i>Paul Smith 190</i> | |

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

Arthur W. Heilig

Licensed Embalmer No. 3872

P. O. Address Imperia

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.