

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-038580

FILED VS OCT 27 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5102 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>40 years</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3217 Cleveland Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3217 Cleveland Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>TAYLOR</u> Last <u>TAYLOR</u>			4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1960</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/1875</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gardner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gardening</u>	11. BIRTHPLACE (City and state or country) <u>Polk County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>David Taylor</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	14. NAME OF HUSBAND OR WIFE <u>Matilda Taylor</u>
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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>496-09-8748</u>	17. INFORMANT Address <u>David M. Taylor, 89th & Hillcrest</u>
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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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 yrs</u> <u>8 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>	
	DUE TO (c) <u>Chronic Myocarditis</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 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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u>
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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 <u> </u> COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from 4-11-59 to 10-8-60 and last saw her/him alive on 10-8-60.
Death occurred at 12:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank Paul Laurenzano MD</u> (Degree or title)	22b. ADDRESS <u>428 S white ave</u>	22c. DATE SIGNED <u>10-8-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 11, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Palestine Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u>
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24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons, K.C. Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>10-10-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>
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DOCUMENT

BY AFFIDAVIT OF Frank Paul Laurenzano M.D. MEDICAL CERTIFICATION

Dr. Laurangana
Monday between 11:00 & 3
Memorial Med Centre
Emergency Room

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 Marvin D. Preston

Licensed Embalmer No. 5040
P. O. Address K. C. D.

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 is not embalmed, fact should be so stated above.

Copy 1 + 2 06-21-02