URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10362 STATE FILE NUMBER 60-040298

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. # 1 — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N/O.
b. COUNTY
c. CITY OR TOWN: ST.LOUIS,MO — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5800 ARSENAL ST. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Lynn Middle (illegible) Last Taylor
4. DATE OF DEATH: Month 9 Day 24 Year 60
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10/2/85
9. AGE (last birthday): 74
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (City and state or country): GA.
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: JOHN
13b. MOTHER'S MAIDEN NAME: MARY SULLIVAN
14. NAME OF HUSBAND OR WIFE: ~
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ? (If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: ST.LOUIS CITY HOSP. #1. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia 2nd/ary to
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): generalized arteriosclerosis obliterans
DUE TO (c): c̄ severe cerebral arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 334X

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 9-17-60, to 9-24-60 and last saw her/him alive on 9-24-60
Death occurred at 7:40 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] MD
22b. ADDRESS: 1515 LAFAYETTE AVENUE
22c. DATE SIGNED: 9-24-60

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 10-31-1960
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland-Aker Mortuary Service
ADDRESS: 4104 Manchester Ave.
25. DATE REC'D BY LOCAL REG.: OCT 26 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

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_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.