

FILED VS NOV 23 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-60-043069

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 224

| | | | | | | | |
|--|----------------------------------|--|--|---|---|---|-------|
| 1. PLACE OF DEATH a. COUNTY <u>Shelby</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>ST. Louis 219²</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>McFarland Hosp</u> | | Length of stay in lb <u>3 years</u> | | d. STREET ADDRESS (If outside, give location) <u>4152 Westminister</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>(No)</u> Last <u>Taylor</u> | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 23 1870</u> | 9. AGE (In years last birthday) <u>90</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (City and state or country) <u>Memphis Tenn.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>UNKNOWN Chambers</u> | | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>George W. Taylor Dead</u> | | |
| 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>None</u> | | 17. INFORMANT <u>Mr Karl Krash</u> Address <u>1944 PISTWAY DR. 1774 1/2 Hill 14 mo'</u> | | | |
| 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>Arterio-sclerosis far advanced</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>yr</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4560</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | 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. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 <u>June 1958</u> to <u>Nov 14, 60</u> and last saw her alive on <u>Nov 14, 60</u> Death occurred at <u>12:00 m. NIGHT</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE <u>James M. Jones M.D.</u> (Degree or title) | | 22b. ADDRESS <u>Rolla, Mo.</u> | | 22c. DATE SIGNED <u>11/15/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>Nov. 17-1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>ZION</u> | | 23d. LOCATION (City, town, or county) (State) <u>ST Louis Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Jay B. Smith</u> | | ADDRESS <u>Rolla, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>Nov. 15, 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u> | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Alth,
elfare
lic
vice00
57

All diseases in Part I must be causally related.

NOV 29 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Herman J. Hoener*

Licensed Embalmer No. *4673*

P. O. Address *Osaka, Mo*

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.