

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044772

FILED VS NOV 17 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3057

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST LOUIS				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 ROCK MO		Length of stay in 1b 100 days		c. CITY OR TOWN ST LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION ROBT KOCH HOSP			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 414 MONTROSE			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SAM Middle Last TAYLOR				4. DATE OF DEATH Month SEPT Day 23 Year 1960			
5. SEX MALE	6. COLOR OR RACE Nonwhite	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Feb 1, 1895	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (City and state or country) INDIANA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME SAM TAYLOR			13b. MOTHER'S MAIDEN NAME CHARLOTTE WAYNE			14. NAME OF HUSBAND OR WIFE MATTIE TSYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Hospital Record Robert Koch Hosp			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA						INTERVAL BETWEEN ONSET AND DEATH 3-4 MO?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 162.1							
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 JUNE 15/60 to SEPT 23/60 and last saw him alive on 9-23-60 Death occurred at 6:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Frank Cohen MD				22b. ADDRESS Robert Koch Hosp Rock Mo		22c. DATE SIGNED 9/24/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical		23d. LOCATION (City, town, or county) St. Louis Mo.		(State)
24. FUNERAL DIRECTOR ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo				25. DATE RECD. BY LOCAL REG. 10-21-60		26. REGISTRAR'S SIGNATURE John B. Manjary M.D.	

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 Anatomical, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Mary Kearney
Licensed Embalmer No. _____

P. O. Address _____

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.