URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 5 1961

-60-048380

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3718

INDED

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN
Length of stay in Ib 2mos.4 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Halls Ferry Nursing Home
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Bellefontaine Neighbors
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1123 Dunford Dr.
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: MIDA Middle: C Last: TAGGARD
4. DATE OF DEATH Month: December Day: 23 Year: 1960
5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 9/13/1960
9. AGE (last birthday): 75 years
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Arkansas
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Nathan Bozarth
13b. MOTHER'S MAIDEN NAME: Virginia Graves
14. NAME OF HUSBAND OR WIFE: Robert N. Taggard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 495-36-3585
17. INFORMANT: Homer Thorpe Address: 1123 Dunford Dr.

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) ARTERIOSCLEROSIS, GENERALIZED
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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)
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 10/31/60, to 12/23/60 and last saw her/him alive on 11/26/60
Death occurred at 1:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Earl W. Lamm, MD
22b. ADDRESS 6000 W Florissant
22c. DATE SIGNED 12/24/60

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: Dec 26, 1960
23c. NAME OF CEMETERY OR CREMATORY: Graceland Cemetery
23d. LOCATION (City, town, or county) (State): Conway Missouri

24. FUNERAL DIRECTOR ADDRESS: BUCHHOLZ MORTUARY-5967 W. Florissant Ave
25. DATE RECD. BY LOCAL REG.: 12-24-60
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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.