

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036022

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. _____ Registrar's No. 1028

AMENDED

FILED OCT 23 1961

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tremont</u>		Length of stay in 1b <u>5 1/2 yrs.</u>	c. CITY OR TOWN <u>Easton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 Mi. South of Easton on Hwy. 31</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 Mi. South of Easton on Hwy 31</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Hiram</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19 1888</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Agency, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Robert W. Taylor</u>		13b. MOTHER'S MAIDEN NAME <u>Mary M. Snyder</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Taylor</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.	17. INFORMANT <u>Mrs Raymond Dreyer Agency, Mo</u> Address
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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>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
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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
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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.)	
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 4-19-67 to 10-12-61 and last saw her/him alive on 8-4-61
Death occurred at 3:05 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr L H Fuson</u>	22b. ADDRESS <u>Mo - St. Joseph, Mo</u>	22c. DATE SIGNED <u>10-13-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 14, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Frazier Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Buchanan County Mo.</u>
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24. FUNERAL DIRECTOR <u>Clarence E. Hinson - Lower, Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Oct. 13, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>
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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

L.H. FUSON, M.D. MEDICAL CERTIFICATION

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 Clarence E. Hipson

Licensed Embalmer No. 5122

P. O. Address Lawer, 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.