SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-042955

STATE FILE NUMBER

AMENDED

DATE AMENDED 7/2

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10866

FILED DEC 12 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2303A University St
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2303A University Street
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Tennie Middle: Last: Taylor
4. DATE OF DEATH: Month: Nov. Day: 20th Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH: 12/24/1884
9. AGE (last birthday): 76
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): Retired
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: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Late Arthur Taylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
17. INFORMANT: Allen Taylor, 2303 University St. 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): Coronary Occlusion,
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arterio Sclerosis.
DUE TO (c): 4201
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 [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
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 ____ to ____ and last saw her/him alive on ____
Death occurred at 6:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Helen L. Taylor, Coroner (Degree or title)
22b. ADDRESS: 1300 Clark Ave.
22c. DATE SIGNED: 11-22-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11/24/1961
23c. NAME OF CEMETERY OR CREMATORY: St. Mathews Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Leidner Und. Co. ADDRESS: 2223 ST. Louis, Mo.
25. DATE RECD. BY LOCAL REG.: NOV 22 1961
26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.

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 Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address St Louis

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.