

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15551

1. PLACE OF DEATH

County Wayne Registration District No. 65-
Township Lafayette Primary Registration District No. 6192
City _____ (No. _____) St. _____ Ward _____

File No. 5
Registered No. _____

2. FULL NAME

John Taylor
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Ann Taylor
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/20/1841
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 92 1 9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Call Co, Mo

13. NAME Hubbard Taylor

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boziah Miss

15. MAIDEN NAME no not know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) E. B. Taylor Patterson Miss

18. BURIAL, CREMATION, OR REMOVAL PLACE Patterson DATE 4/30 19. 33

19. UNDERTAKER (ADDRESS) Piedmont, Mo

20. FILED 4-29- 19. 33 Ms. T. M. Polk Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-29 19. 33

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 19. 33, to April 7 19. 33
I last saw him alive on 4-7- 19. 33 Death is said to have occurred on the date stated above, at 11 A m.

The principal cause of death and related causes of importance were as follows:

Senile Debility
11 A / 162
Date of onset _____
Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19. _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____
(Signed) C. J. Spurr, M.D. _____
(Address) Piedmont, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 24 1933

