

APR 12 1939

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

8493
Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City St. Louis (d) Street No. McBaptist Hospital (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

791

1003

2258

2. PRINT FULL NAME 460 Catherine Taylor

(a) Residence, No. 6188 McPherson Ave. St. 5 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF David Taylor
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 27 - 1850
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
88 6 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as 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) Ky

FATHER 13. NAME Wm Ramsey 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER 15. MAIDEN NAME Not Known 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

17. INFORMANT (ADDRESS) Mrs Betty May 6188 McPherson St

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine Cem DATE 3-9-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Exd Maxwell 4525 Vandeventer St

20. FILED MAR 9 1939 J. B. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-7-1939
22. I HEREBY CERTIFY, That I attended deceased from 3-2-1939 to 3-7-1939

I last saw her alive on Mar 7, 1939 Death is said to have occurred on the date stated above, at 4 p.m.

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

Bronchopneumonia, terminal 3/2/39
Cerebral hemorrhage Jan '35
Arteriosclerosis, general

Other contributory causes of importance:
Cerebral hemorrhage
Arteriosclerosis, general

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? yes

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? no
If so, specify.....
(Signed) Truman H. Drake, M.D.
(Address) 114 N. Taylor, St. Louis

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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Guy W. Wilkenson

Licensed Embalmer No. 3575

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 this body is not embalmed, above space should be left blank.