

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.

REC'D JUL 10 1939

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

21107
Do not use this space.

1. PLACE OF DEATH

(a) County JACKSON 1 Registration District No. 399

(b) Township KAW 1 Primary Registration District No. 1002 Registered No. 2275

(c) City KANSAS CITY (d) Street No. ST. JOSEPH'S HOSPITAL St. (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. 460 Mo 9 Virgini Marlow Taylor (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Mrs. J. L. (Virginia Marlow Taylor)

(a) Residence, No. 3609-FOREST AVENUE St. (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) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF JAY L. TAYLOR

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCTOBER-4-1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>30</u>	<u>8</u>	<u>5</u>	

OCCUPATION

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) ILLINOIS 1

FATHER

13. NAME ANGELO MARLOW 7

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ITALY 7

MOTHER

15. MAIDEN NAME UNKNOWN

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

17. INFORMANT MR JAY L. TAYLOR
(ADDRESS) 3609-FOREST AVENUE

18. BURIAL, CREMATION, OR REMOVAL
PLACE CARBONDALE, ILLINOIS DATE JUNE-9-1939

19. FUNERAL DIRECTOR (NAME) D. W. NEWCOMER'S SONS
(ADDRESS) KANSAS CITY, MISSOURI

20. FILED June 8, 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-9-39 19

22. I HEREBY CERTIFY, That I attended deceased from Pathologist, 19

I last saw him/her alive on 6-8-39, 19. Death is said to have occurred on the date stated above, at 4:30 p.m.

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

Postoperative Shock -
General Anesthesia

Date of onset 129a

Other contributory causes of importance:

Name of operation Removal of ovary and cyst Date of 6-5-39

What test confirmed diagnosis? Biopsy 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? _____
If so, specify _____
(Signed) Dr. Russell W. Jones M. D.
(Address) _____

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 E. M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. C. 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 this body is not embalmed, above space should be left blank.