DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6765

FILED MAR 15 1940

Registration District No. ____ Primary Registration District No. 5 5 9 ____ Registrar's No. 2

1. PLACE OF DEATH:

(a) County Hickory Co

(b) City or town Hermitage (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Center (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community all his life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Hickory

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. ____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME JAMES C. TAYLOR 460

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Jan. (Month) 19 (Day) 1891 (Year)

8. AGE:	Years	Months	Days	If less than one day
	49	1	3	____ hr. 8-30 A min.

9. Birthplace Hickory Co (City, town, or county) ____ (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ____

FATHER
12. Name Dennis D Taylor
13. Birthplace Tenn. (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name Sarah Brannon
15. Birthplace Hickory Co (City, town, or county) ____ (State or foreign country)

16. (a) Informant's own signature Olen Taylor

(b) Address Hermitage

17. (a) Doley Bend (Burial, cremation, or removal) (b) Date thereof Feb-23-40 (Month) (Day) (Year)

(c) Place: burial or cremation Dooley Bend

18. (a) Signature of funeral director Hutchins & Co

(b) Address Bolivar Mo

19. (a) Feb-24-40 (Date received local registrar) (b) Anice McKinley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21 year 1940 hour ____ minute 8-30 A M.

21. I hereby certify that I attended the deceased from 1/10/40 ____, 19__, to 1/21/40, 19__; that I last saw him alive on 2/15/40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Kidney	4 mo
Due to Infectious and Syphilis	
Due to ____	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? Hermitage (City or town) Hickory (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature L A Glaser (M. D. or other) MD

Address Urbana Mo Date signed 2/21/40

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

50M-5-17-39
Rev. 5-17-39
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Officer No. 7,
Number 3-40-334
Date Filed 3/4/40

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 [illegible]

Licensed Embalmer No. 1331

P. O. Address [illegible]

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.