

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16206

State File No. _____

Registration District No. 7-977

Primary Registration District No. 4477

Registrar's No. 757

1. PLACE OF DEATH:

(a) County Saline
 (b) City or town Miami
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location) 2
 (d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
 (c) City or town Miami
 (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 Julia E. Taylor
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 14, 1878
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 28th year 1940 hour 11:40 minute _____ M.
 21. I hereby certify that I attended the deceased from 10-21-39 to April 28-40 1940
 that I last saw her alive on April 28-40 1940 and that death occurred on the date and hour stated above.

8. AGE: Years 61 Months 9 Days 16 If less than one day _____ hr. _____ min.

Immediate cause of death Cardiac Failure Duration 10 hrs.
 Due to Cardiac muscle / abnormal. Valves. 7 mo.
 Due to _____

9. Birthplace Warren Co Ky. (City, town, or county) (State or foreign country)
 10. Usual occupation housewife

Other conditions Arteriosclerosis (Include pregnancy within 3 months of death)
 Major findings: Of operations None
 Of autopsy None

11. Industry or business _____
 MOTHER FATHER
 12. Name Geo. J. Taylor
 13. Birthplace Georgetown Ky. (City, town, or county) (State or foreign country)
 14. Maiden name Emma Sweeney
 15. Birthplace Warren Co Ky. (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) None
 (b) Date of occurrence None
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? None
 (Specify type of place) (e) Means of injury

16. (a) Informant's own signature Mary Sweeney
 (b) Address Miami Mo
 17. (a) _____ (b) Date thereof April 29/1940 (Month) (Day) (Year)
 (c) Place: burial or cremation Miami
 18. (a) Signature of funeral director Campbell Lewis
 (b) Address Marshall Mo
 19. (a) Apr. 30-40 (b) Mrs. Arlene Hulse (Data received local registrar) (Registrar's signature)

23. Signature A. E. Ecklund (M. D. or other) 7/79
 Address Staten Mo Date signed _____

588

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.....

 R. W. Campbell , Registered Apprentice No.....
working under my personal supervision.

Signed *R. W. Campbell*

Licensed Embalmer No. 3469

P. O. Address *Marshall, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *16208*

Registration District No. *797*

Primary Registration District No. *4477*

Registrar's No. *7*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County *Saline*
(b) City or town *Miami*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME *Julia E. Taylor*

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

4. Sex *7* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *2*

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years *61* Months *9* Days *16* If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Apr* day *28* year *1940* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death *Cardiac failure*
Carcinoma of abdomen
Due to *myocardial*
arteriosclerosis
Due to *arteriosclerosis*
Other conditions *arteriosclerosis*
(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? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature *H. E. Lockwood* (M. D. *Apr 30*)
Address *Slater, Mo.* Date signed *40*

SUPPLEMENTAL

