S. No. 2
—11-10-39
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19484

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 1096

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Louis County Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mo. 24 days (Specify whether years, months or days)

In this community 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Wheaton Sta. (If outside city or town limits, write "RURAL")

(d) Street No. 8209 Albin (If rural, give location)

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

3. (a) PRINT FULL NAME Bird M. Taylor 460

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 married

6. (b) Name of husband or wife Robert E. Taylor

6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased Jan. (Month) 1 (Day) 1900 (Year)

8. AGE: Years 40 Months 5 Days 3 If less than one day ____ hr. ____ min.

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

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Samuel Chandler
13. Birthplace Unknown (City, town, or county) N. Carolina (State or foreign country)

MOTHER
14. Maiden name Josephine Scoggins
15. Birthplace Unknown (City, town, or county) N. Carolina (State or foreign country)

16. (a) Informant Robert Taylor

(b) Address 8209 Albin

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-40 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont

19. (a) JUN 6 - 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4 year 1940 hour 7 minute :25 P. M.

21. I hereby certify that I attended the deceased from 3-11-40, 19__, to 6-4-40, 19__; that I last saw her alive on 6-4-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary congestion	3 hrs.
Obstructive Jaundice	3 1/2 mo.
Due to Cholecystitis & lithiasis	10 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Cholecystitis & lithiasis

Of autopsy Lung abscess - Beliny cirrhosis

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature M. A. Murphy (M. D. or other) M. A.

Address St. Louis Co. Hosp. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 [signature]

Licensed Embalmer No. 3225

P. O. Address 1125 Hadrimont Ave

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.