

No. 2
4-13
5-17-39
PI X2515

State File No. _____

Registrar's No. _____

Registration District No. 845

Primary Registration District No. 6109

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

1. PLACE OF DEATH

(a) County Stone James H.

(b) City or town Reeds Springs, Mo.
(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 practically entire life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Stone

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

(d) Street No. East James TP?
(If rural, give location)

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

3. (a) PRINT FULL NAME Mathe Taylor 460

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 6th, 1940, to 6-22-40, 19____; that I last saw her alive on 6-19-40, 19____; and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife W. S. Taylor 6. (c) Age of husband or wife if alive 9 years
(Month) (Day) (Year)

7. Birth date of deceased Jan 9 1887
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration _____

8. AGE: Years 73 Months 5 Days 21 If less than one day _____ hr. _____ min.

Due to High Blood Pressure

Due to _____

9. Birthplace Indiana Stubain Co.
(City, town, or county) (State or foreign country)

Other conditions Fracture Right hip
(Include pregnancy within 3 months of death)

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER { 12. Name Ezra Morris

13. Birthplace W. S.
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

Major findings: Of operations Int. Cerebral

Of autopsy _____

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

16. (a) Informant Clara Barron

(b) Address Reeds Springs, Mo.

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? Yes

17. (a) Burial (b) Date thereof 6/23/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Fair

(Specify type of place) _____
While at work _____ (Specify means of injury)

18. (a) Signature of funeral director Everett J. Cheatham

(b) Address Malena, Mo.

23. Signature W. P. Cottrell M.D. (M. D. or other) _____

19. (a) 6/28/40 (b) W. P. Cottrell
(Date received local registrar) (Registrar's signature)

Address Reeds Springs, Mo. Date signed 6/28/40

RECEIVED

District Health Officer No. 6,

District File Number 7460-1490

Date Filed JUL 5 1948

JUL 5 1948

1948
99

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22991**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **845**

Primary Registration District No. **6109**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County: Stone

(b) City or town: James T. P.
(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 Mattie Taylor

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: wid

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	Months	Days	If less than one day
<u>73</u>	<u>5</u>	<u>21</u>	_____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 June day 22
year 1940 hour _____ minute _____ M.

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

Immediate cause of death: High Blood Pressure

Due to: Apoplexia that occurred before fall about June 4th, she was not at work.

Due to: Cerebral Hemorrhage

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Fract. Rt. hip - 1938

Of operations: _____

Of autopsy: _____

Duration

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? Fall.

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature: H. P. Cattrell (M. D. or other) _____

Address: Reeds Spring Date signed: _____

SUPPLEMENTARY

S-22991