

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 387

Primary Registration District No. 5940

Registrar's No. _____

1. PLACE OF DEATH:

(a) County HOWELL

(b) City or town RURAL DRY CREEK TWP.
(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 No.
(Specify whether years, months or days)

In this community 53 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL

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

(d) Street No. WEST PLAINS Mo. Rural Rt.
(If rural, give location)

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

3. (a) PRINT FULL NAME MAGGIE TAYLOR

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 23
year 1941 hour 9 minute _____ P. _____ M.

4. Sex FEMALE 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Abe Taylor

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

7. Birth date of deceased DEC. 6, 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 1, 1941 to March 23, 1941; that I last saw her alive on March 18, 1941; and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 3 Days 18
If less than one day hr. _____ min. _____

Immediate cause of death Myo-Carditis, chronic with valvular disease
Duration 2 years

9. Birthplace OXFORD MISS. 1
(City, town, or county) (State or foreign country)

Due to Myo-Carditis, chronic with valvular disease

Due to _____

10. Usual occupation Farmer

Other conditions General Anasarca
(Include pregnancy within 3 months of death)

11. Industry or business Own Farm.

MOTHER { 12. Name Unknown

FATHER { 13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

Major findings: Of operations None

Of autopsy None

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

16. (a) Informant's own signature S. Mo. O.A.A. Office

(b) Address West Plains, Mo.

17. (a) BURIAL (b) Date thereof MAR. 25, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOWELL CO., DRY CREEK TWP. SADIE BROWN CEM.

18. (a) Signature of funeral director Hal Thornburgh

(b) Address WEST PLAINS, MO.

19. (a) March 31 (b) Done page.
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature A. H. Thornburgh (M. D. _____)

Address West Plains, Mo. Date signed 3/28/41

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.

RECEIVED

District Health Officer No. 5,

District File Number 441770

Date Filed _____

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, above space should be left blank.