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FILED JUN 16 1941  
908

Registration District No. \_\_\_\_\_

Primary Registration District No. 6222

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Wright  
(b) City or town Rural Mt 114  
(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 D. G. Taylor

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 Married

6. (b) Name of husband or wife Josie Taylor 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 14 1869  
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Ed Taylor

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Os Taylor

(b) Address Mt Grove Mo

17. (a) Rural (Burial, cremation, or removal) (b) Date thereof 5-21-41 (Month) (Day) (Year)

(c) Place: burial or cremation Love Star

18. (a) Signature of funeral director Wm L Barber

(b) Address Mt Grove Mo

19. (a) 5-21-41 (Date received local registrar) (b) Bernie M. Magney (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright  
(c) City or town Rural 114  
(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 May day 18 year 1941 hour 6:30 minute a M.

21. I hereby certify that I attended the deceased from May 10 1941, to May 18 1941, that I last saw him alive on May 17 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
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? \_\_\_\_\_

\$31 (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Wm L Barber (M. D. or other) \_\_\_\_\_  
Address Mt Grove Mo Date signed 5-21-41

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

RECEIVED

District Health Officer No. 6,

District File Number 641-950

Date Filed JUN 13 1941

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 Russell Barber

Licensed Embalmer No. 3848

P. O. Address Mt. Grove

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19346

Registration District No. 908

Primary Registration District No. 6222

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Mountain Grove 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 G Taylor

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 4  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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) 5-21-41 (b) Gerine Matzinger  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18  
year \_\_\_\_\_ 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 \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_  
(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 R. W. Kerney (M. D. or other) \_\_\_\_\_

Address Mountain Grove, Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

19346