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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 6 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15571

State File No.

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 950

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Koch, Hosp. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 2-26-43 to 4-18-43 (Specify whether
In this community 26 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County — 000 17

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 1317 S. 7th St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME ALICE FLORENCE TAYOAN

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Edward Tayoan

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

7. Birth date of deceased 7 (Month) 14 (Day) 1897 (Year)

8. AGE: Years 45 Months 9 Days 4 If less than one day hr. min.

9. Birthplace St. Charles (City, town, or county) Mo O (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Fred Kohl
13. Birthplace St. Charles (City, town, or county) Mo. O (State or foreign country)

MOTHER
14. Maiden name Alice Tayoan TAYON
15. Birthplace Missouri (City, town, or county) O (State or foreign country)

16. (a) Informant Record at Koch Hosp

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/43 (Month) (Day) (Year)

(c) Place: burial or cremation St Charles

18. (a) Signature of funeral director L. A. W. McLaughlin

(b) Address 2301 Ray av. Ste Ave

19. (a) APR 22 1943 (Date received local registrar) (b) C. H. McKinney, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 18 year 1943 hour 6 minute 50 A.M.

21. I hereby certify that I attended the deceased from 2-26, 1943, to 4-18, 1943 that I last saw her alive on 4-18, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulm. tbc	1½ yrs
Due to tubercle bacilli	
Due to	
Other conditions Intest tbc (Include pregnancy within 3 months of death)	?

Major findings:
Of operations 13 Li
Of autopsy Confirms above

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 Bernard Freedman (M. D. or other) M.D.

Address Koch Hosp, Koch Mo. Date signed 4-18-43

(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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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.