

6  
11  
11

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

FILED AUG 9 1943

State File No.

Registrar's No.

Registration District No. 141 Primary Registration District No. 141-1

1. PLACE OF DEATH:  
(a) County Honell  
(b) City or town Rural Honell Mo  
(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 4 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Ark (b) County Fulton  
(c) City or town Salem  
(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 2

3. (a) PRINT FULL NAME M. J. TAYLOR  
(b) If veteran, name war  (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 6th year 1943 hour 3 minute 0 P. M.  
21. I hereby certify that I attended the deceased from 5/6/43 to 7/6/43

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 2  
6. (b) Name of husband or wife Ella Taylor 6. (c) Age of husband or wife if alive 76 years  
7. Birth date of deceased Feb 18-1867  
(Month) (Day) (Year)

that I last saw him alive on May 6th, 1943, 19... and that death occurred on the date and hour stated above.

Immediate cause of death Some form of heart failure.

8. AGE: Years 86 Months 5 Days 18 If less than one day hr. min.

Due to Myocarditis, Chr. with valvular insufficiency.  
Due to Arthritis, Chron.

Other conditions Arthritis, Chron.  
(Include pregnancy within 3 months of death)

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

Major findings: Of operations none

10. Usual occupation Farmer

Of autopsy none

11. Industry or business Farmer

12. Name Frank Taylor

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

14. Maiden name Elizabeth Mathews

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

16. (a) Informant Oliver Taylor

(b) Address Bakersfield Mo.

17. (a) (Burial, cremation, or removed) R (b) Date thereof July 6-43 (Month) (Day) (Year)

(c) Place: burial or cremation  Baptist Hill Cem

18. (a) Signature of funeral director W. J. ...

(b) Address ...

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Not  
(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?

23. Signature Arthur ... (M. D. or other) West Plains, Mo. Date signed 7/6/43

RECEIVED

District Health Officer No. 5,

District File Number 843479

Date Filed 8-6-43

---

**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.**

Registration District No. 14

Primary Registration District No. 5551

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town Rural Howell 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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME M. J. 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 W

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

7. Birth date of deceased Feb 18 1880  
(Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days \_\_\_\_\_ (less than one day) \_\_\_\_\_ min.

9. Birthplace Mo  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day \_\_\_\_\_  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-25094