

FILED DEC 6 1943

Registration District No. 42

Primary Registration District No. 1000

State File No. _____

Registrar's No. 1230

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

1. PLACE OF DEATH: Buchanan.

(a) County... St. Joseph. Mo.

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

(c) Name of hospital or institution: Missouri Methodist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution... (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Samuel Taylor.

3. (b) If veteran, name war... 3. (c) Social Security No...

4. Sex Male 0 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma Taylor. 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased August 30 1862 (Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 7 If less than one day

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

10. Usual occupation Farmer.

11. Industry or business

MOTHER FATHER { 12. Name James J. Taylor.

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

14. Maiden name Louise Henry.

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

16. (a) Informant Kansas City. Mo.

(b) Address Burial

17. (a) (Burial, cremation, or removal) Mound City (b) Date thereof Nov. 10/43 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Pettejohn Crawford

(b) Address Mound City Mo.

19. (a) 11-10-43 (Date received local registrar) (b) Rose Hazy (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt 044

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

(d) Street No... (If rural, give location)

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

If yes, name country...

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 6th. year 1943 hour 3 PM. minute M.

21. I hereby certify that I attended the deceased from Oct 29 1943 to Nov 6 1943; that I last saw him alive on Nov 6 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to... 93d

Other conditions Hypertrophy of Prostate (Include pregnancy within 3 months of death)

Major findings: Of operations Hypertrophy of Prostate

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) Means of injury

23. Signature Dr. Chas. Frank... (M. D. or) Address Pr. Chas. Frank... Date signed 11/9/43

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. 1824

P. O. Address *Wound City Mo*

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.