

FILLED MAY 13 1946

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

Primary Registration District No. 3059

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

1. PLACE OF DEATH:  
(a) County St. Francois  
(b) City or town Bonne Terre  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 216 Fite St.  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Francois  
(c) City or town Bonne Terre  
(If outside city or town limits, write "RURAL")  
(d) Street No. 216 Fite  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PERLEOTIS TAYLOR  
(b) If veteran,  name war \_\_\_\_\_  
(c) Social Security No. UNKNOWN

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 28th  
year 5 hour 20 minute P.M.  
21. I hereby certify that I attended the deceased from Jan. 10-44  
to Apr. 28- 1944  
that I last saw him alive on Apr. 28- 1944  
and that death occurred on the date and hour stated above.

4. Sex M | 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Eula Taylor  
(c) Age of husband or wife if alive 52 years  
7. Birth date of deceased: April 16 1890  
(Month) (Day) (Year)

Immediate cause of death Menia.  
Due to Pyonephrosis  
Nephritis  
Due to Infected teeth.  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years | Months | Days | If less than one day  
54 | 0 | 12 | hr. \_\_\_\_\_ min.  
9. Birthplace Jackson Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Merchant

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
12. Name Robert Patterson Taylor  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Alice Cecelia Miller  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eula Taylor  
(b) Address 216 Fite, Bonne Terre Mo  
17. (a) Burial (b) Date thereof Apr. 30, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation B. J. Cemetery  
18. (a) Signature of funeral director Berkman 2nd Co  
(b) Address 313 Berkman, Bonne Terre Mo  
19. (a) 5-4-44 (b) Donald St. John  
(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?  
While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature H. P. Patton (M. D. or other) \_\_\_\_\_  
Address Bonne Terre Mo Date signed 5-1-44

1373

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

RECEIVED

District Health Officer No. 4

District File Number 544-38

Date Filed 5-13-44

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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

*A. J. Claywell*

Licensed Embalmer No. 3706

P. O. Address *Bonnie Lane*

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. 316

Primary Registration District No. 3059

1. PLACE OF DEATH:  
(a) County St. Francois  
(b) City or town Bonne Terre  
(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 Perle O. 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. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: April 16 (Month) (Day) (Year)  
8. AGE: Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ min.)

9. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (Data 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 April year 1944 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 hemiplegia

Due to Hypertension

Due to Nephritis + Pyelitis + Infected teeth

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ 133a 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (2) Means of injury \_\_\_\_\_

23. Signature H. P. Weston (M. D. or other) \_\_\_\_\_

Address Bonne Terre, Mo. Date signed 5-16-44

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

SUPPLEMENTARY

H. P. Poston

June 1899

19699