

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Jasper
 (b) City or town Jasper
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
(Specify whether
 In this community 24 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jasper
 (c) City or town Jasper
(If outside city or town limits, write "RURAL")
 (d) Street No. Rt 1
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Elmer 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: September 13 1868
(Month) (Day) (Year)

8. AGE: 78 Years 7 Months 20 Days
 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business Housewife
MOTHER FATHER
 12. Name Johnny Hargis
 13. Birthplace don't know
(City, town, or county) (State or foreign country)
 14. Maiden name don't know
 15. Birthplace don't know
(City, town, or county) (State or foreign country)

16. (a) Informant: Elmer Taylor
 (b) Address: Rt 1 Jasper

17. (a) burial (b) Date thereof: 12-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Fareot Park Cem

18. (a) Signature of funeral director Harrell Dillon
 (b) Address Jasper Mo

19. (a) 12-9-46 (b) A. J. Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5
 year 1946 hour 6 minute 10 M.
 21. I hereby certify that I attended the deceased from 12-5-46
7:57 1946, to Dec-5-46 1946
 that I last saw her alive on Dec-5-46 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death: fluxion
trans to his left
side of body

Due to _____
 Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION

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)
 (c) Means of injury _____

23. Signature E. E. Coats (M. D. or other) MD
 Address Joplin Mo Date signed 12-7-46

46-12-1063

DEC 19 1958

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 David Dillon

Licensed Embalmer No. 3898

P. O. Address Joplin, 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.

0561 0 1950

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan*
Registrar's No. _____

Registration District No. *156*

Primary Registration District No. *2001*

1. PLACE OF DEATH:

(a) County *Jasper*
(b) City or town *Joplin*
(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 *Henrette Taylor*
(b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex *F* 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 _____

7. Birth date of deceased *Sept 13*
(Month) (Day) (Year)

8. AGE: Years *78* Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) *Iowa*

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 _____ Year *1946* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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) *Gas Burns to*

(b) Date of occurrence *Nov. 25-1946*

(c) Where did injury occur? *Joplin Jasper, Mo.* (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *Home*

While at work? *Yes* (Specify type of place) (c) Means of injury *Burn*

23. Signature *E. E. Coats M.D.* or other _____

Address *Joplin Mo.* Date signed *1-1-47*

SUPPLEMENTARY

MOTHER FATHER

41037