

FILED MAR 31 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

8420

Registration District No. 86

Primary Registration District No. 5322

Registrar's No.

12-1947

1. PLACE OF DEATH:

- (a) County Crawford
 (b) City or town Highway 66, Hwy 3 1/2 Mi. West
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: of Cuba mo. 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether

In this community
years, months or days3. (a) PRINT
FULL NAMEAllen Taylor3. (b) If veteran,
name war W.W.I3. (c) Social Security
No.4. Sex M D 5. Color or
race W6. (a) Single, widowed, married,
divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

hr. _____ min.

9. Birthplace

(City, town, or county)

(State or foreign country)

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

Coroner's Inquest Testimony

(b) Address

Steelville, Mo.17. (a) Funeral Home

(burial, cremation) or removal

(b) Date thereof

3-14-1947

(Month) (Day) (Year)

(c) Place: burial or cremation

Xenia, Ill

18. (a) Signature of funeral director

Frank A. Shankel

(b) Address

Cuba, Mo.19. (a) 3-14-47

(Date received local registrar)

(b) Frank A. Shankel

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Illinois (b) County 999
 (c) City or town XENIA
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location) 2
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1947 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Verdict of Coroner's Duration
Jury: "By accident with truck, Driver
of truck was no way to blame. Unpreventable
by truck driver."

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 sta-
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) Accident 26
 (b) Date of occurrence March 13, 1947
 (c) Where did injury occur? W. of Cuba Crawford, Missouri
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway #66
 While at work? No (Specify type of place) (e) Means of injury Accident
 23. Signature Frank A. Shankel (M.D. or other) 3
 Address Steelville Mo. Date signed 3/14-47

MOTHER FATHER

372

(Licensed Embalmer's Statement on Reverse Side)

Coll. with other m. vehicle

MAY 9 1947
MAY 9 AM
MAY 13 1947

MAY 31 1949

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 *Paul G. Shanks*
Licensed Embalmer No. *3472*
P. O. Address *Cuba, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 86

Primary Registration District No. 6222

1. PLACE OF DEATH:

(a) County Crawford Rural
(b) City or town Rural
(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 Glen 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 _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

9. Birthplace _____ (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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (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 March 1947 year, 13 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ 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 _____

Due to _____

Due to _____

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

Major findings:
Of operations _____
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) _____

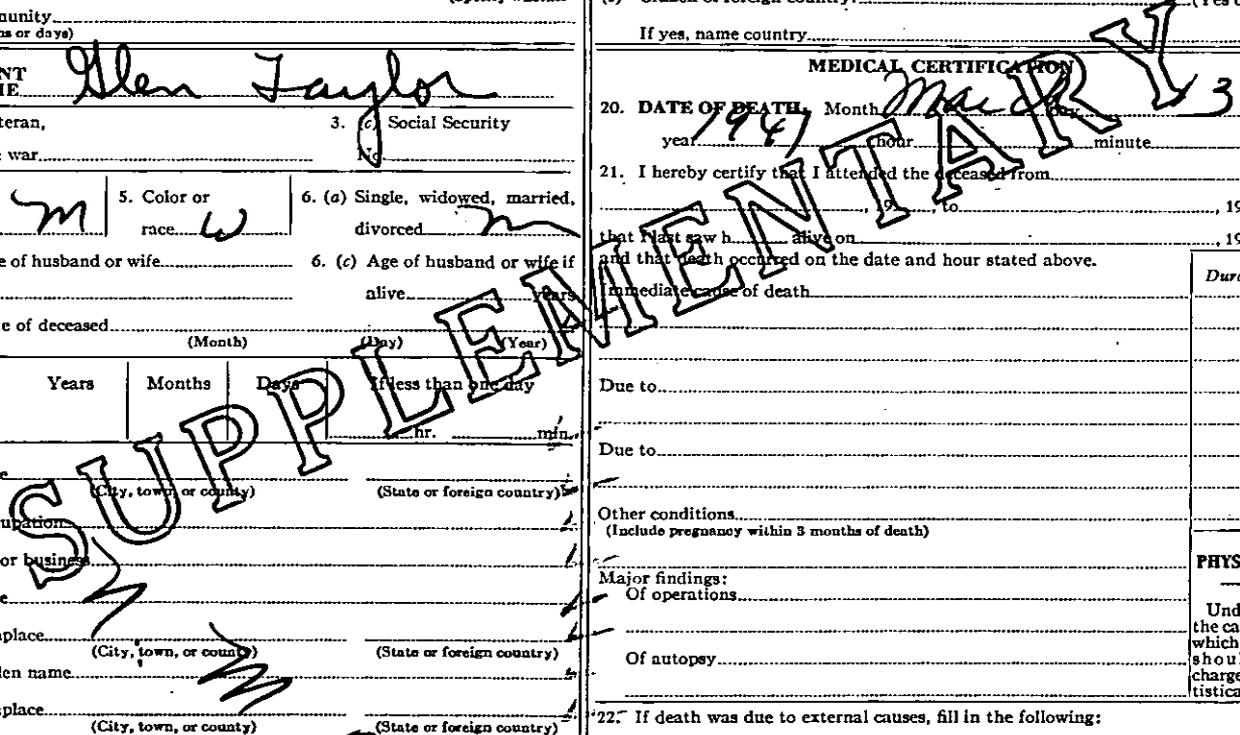
(b) Date of occurrence _____

(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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____



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

8420