

No. 2
-12-45
5-17-39
X47076

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13801

State File No. _____

FILED MAY 5 1947

Registration District No. 15

Primary Registration District No. 5572 5572

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
on 10 E. 4 mi S. of Lees Summit
(If not in hospital or institution, give street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 7yr
years, months or days

3. (a) PRINT FULL NAME Sarah Taliaferro

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F / 1 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Edward P. Taliaferro

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased Feb 26 - 1853
(Month) (Day) (Year)

8. AGE: Years 94 Months 0 Days 28
If less than one day hr. _____ min. _____

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

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER

12. Name unknown

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 Mr. H. E. Purdy

(b) Address Independence Mo RR 4

17. (a) Removal (b) Date thereof 4-24-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Effingham Kan

18. (a) Signature of funeral director W. B. Langford

(b) Address Lees Summit Mo

19. (a) 4-26-47 (b) Donald C. Bouchard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. on 10 E 4 mi North Lees Summit
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1947 hour 6:36 minute _____ P. M.

21. I hereby certify that I attended the deceased from 7-1, 1943, to 4-23, 1947
that I last saw h. ea alive on 4-20, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 15 yrs

Due to _____

Due to _____

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

Major findings: 938

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 W. B. Langford (M. D. or other) MD

Address Lees Summit Mo Date signed 4/24/47

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

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.....

W. B. Langford
.....
Licensed Embalmer No. *3833*
P. O. Address *Lees Summit*

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.