

**FILED SEP 10 1947**  
Registration District No. 3.22

Primary Registration District No. 4472

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

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Slater  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline  
(c) City or town Slater  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Ephrim Taylor

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ollie Taylor 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased April 13 1870  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>4</u>	<u>26</u>	hr. _____ min.

9. Birthplace Saline County Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

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

12. Name unknown

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

14. Maiden name Frances Carter

15. Birthplace No.  
(City, town, or county) (State or foreign country)

16. (a) Informant Claude Taylor

(b) Address Slater, Mo.

17. (a) burial (b) Date thereof 8-12-'47  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Hill Brothers,

(b) Address Slater, Mo.

19. (a) Aug 15, 1947 (b) Mrs. Earl C. Metz  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th  
year 1947 hour 8.30 minute a M.

21. I hereby certify that I attended the deceased from 7-24, 1947 to 8-9, 1947  
that I last saw him alive on 8-6, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Due to Hypertension

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(c) 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 A. Sullivan (M. D. or other) \_\_\_\_\_  
Address Miami, Mo. Date signed 8/10/47

Duration 16 days  
many  
years  
probably  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

7  
2  
1

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-9-47

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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 Sam M. Hill

Licensed Embalmer No. 1292

P. O. Address State 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.