

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED OCT 6 1947
128

Registration District No. _____ Primary Registration District No. **2000** _____

1. PLACE OF DEATH: **GREENE**

(a) County.....
 (b) City or town..... **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Burge Hospital 0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **27 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Webster**
 (c) City or town **Seymour**
(If rural, give location)
 (d) Street No. _____
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **John Rosencrance Taggard**
 (b) If veteran, name war **No**
 (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **11th**
 year **1947** hour **8** minute **25 a.** M.
 21. I hereby certify that I attended the deceased from **Aug 15**
 19 **47** to **Sept. 11**, 19 **47**;
 that I last saw him alive on **Sept. 10, 1947**
 and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **married**
 6. (c) Age of husband or wife if alive **77** years
 7. Birth date of deceased **Jan. 26 1864**
(Month) (Day) (Year)

Immediate cause of death **Pneumonia, terminal**
 Duration **9/10**
9/11

8. AGE:	Years	Months	Days	If less than one day
	83	7	15hr. min.

Due to **Miocardia-insufficiency** **2 weeks**
 Due to **Pyelonephritis** **3 mos.**

9. Birthplace **marshfield Mo.**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Station agent**
 11. Industry or business **Trisco R.R.**
 12. Name **James S. Taggard**
 13. Birthplace **not known Tenn.**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary E. Holland**
 15. Birthplace **not known Tenn.**
(City, town, or county) (State or foreign country)

Other conditions **None**
(Include pregnancy within 3 months of death)
 Major findings: **None**
 Of operations.....
 Of autopsy.....
 PHYSICIAN **None**
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant **Mrs. John Taggard**
 (b) Address **Seymour, Mo.**
 17. (a) **Burial** (b) Date thereof **9 13 47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Seymour Cemetery**
 18. (a) Signature of funeral director **Kelley Terrell Bergman**
 (b) Address **Seymour Mo.**
 19. (a) **9-13-47** (b) **W. E. Handley and**
(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) _____
 (e) Means of injury **0**
 23. Signature **Leslie P. Webb** (M. D. or other) _____
 Address **700 Medical Arts Bldg.** Date signed **9/12/47**
Springfield, Mo.

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

19
2
6

DEC 8 1954

DEC 17 1952

NOV 6 1953

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 H. H. Kelley

Licensed Embalmer No. 3334

P. O. Address Fordland me

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.