

No. 300  
1-10-47  
5-17-39  
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MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26631**  
Registrar's No. **3084**

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

FILED AUG 26 1948  
Registration District No. **219**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
Wheatley Hospital O  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 hrs.  
(Specify whether years, months or days) 32 Years

3. (a) PRINT FULL NAME Marie Taylor

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife Frank G. Taylor 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased March 14, 1915  
(Month) (Day) (Year)

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

33 4 10 hr. min.

9. Birthplace Columbia, Missouri O  
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business

MOTHER FATHER { 12. Name Amos Merritt

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

14. Maiden name Julia Mitchell

15. Birthplace Georgia  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank G. Taylor

(b) Address 2629 Park

17. (c) Burial (b) Date thereof 7/28/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Patricia Boyd

(b) Address 1729 Auding Ave

19. (a) 7-28-48 (b) DeWaldine Palmer  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 2629 Park Avenue 8  
(If rural, give location) O

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th  
year 1948 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from July 23, 1948, to July 24, 1948.

that I last saw her alive on July 24, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Post-partum hemorrhage 146c

Due to Undetermined cause

Due to (full term)

Other conditions (Include pregnancy within 3 months of death)

Major findings: 146c

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 Patricia Boyd (M. D. or other)

Address 2629 Park Date signed 7/26/48

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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.....

*J. M. Moulton*

Licensed Embalmer No.....

*3994*

P. O. Address.....

*2503 Highland*

**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.**