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FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25388

318

1003

Registrar's No. 6612

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO.		Registrar's No. 6612	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 17		d. STREET ADDRESS 817 Market	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hosp #10				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) William Taylor				b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) 6 28 49	
5. SEX Male		6. COLOR OF HAIR		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED		8. DATE OF BIRTH Apr 1902	
9. AGE (In years, months, days)		IF UNDER 1 YEAR Months Days		IF UNDER 1 HS. Hours Min.		11. BIRTHPLACE (State or foreign country) Mo.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) (If yes, state year and date of service)		16. SOCIAL SECURITY NO.		17. DECEASED'S SIGNATURE OR NAME T. Taylor			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 950		21f. HOW DID INJURY OCCUR? +345	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, _____, from the causes and on the date stated above.							
23a. SIGNATURE Joseph M. [Signature]				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 7/15/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Jul 31 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 31 1949 J. B. [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.				ADDRESS	

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

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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 _____

working under my personal supervision.

Student Embalmer No.

Signed Ralph W. Henson

Signed
Student Embalmer .

Licensed Embalmer No. 3221

P. O. Address St. Louis, 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.