No. 300
10-48

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

FILED NOV 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37535

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 2002 Registrar's No. 4570

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Childrens Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Saline 97
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Slater
d. STREET ADDRESS (If rural, give location): 304 Locust St.

3. NAME OF DECEASED (Type or Print)
a. (First): Larry
b. (Middle): Gene
c. (Last): Taylor

4. DATE OF DEATH (Month) (Day) (Year): Oct 24 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: May 31 1947
9. AGE (In years last birthday): 2 — IF UNDER 1 YEAR: Months ~~4~~ Days ~~25~~ — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Barnett, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Kenneth Taylor
13b. MOTHER'S MAIDEN NAME: Betty Hightower
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mrs Betty Taylor — ADDRESS: Slater, Mo.

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): Anemia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Acute Leukemia
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
20-13
20. AUTOPSY? YES ☒ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Oct 14~~, 19~~49~~, *to* ~~Oct 25~~, 19~~49~~, *that I last saw the deceased alive on* ~~Oct 24~~, 19~~49~~, *and that death occurred at* 2:50 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: E.C.H. Schmidt (Degree or title): M.D.
23b. ADDRESS: K.C. Mo
23c. DATE SIGNED: Oct 25 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 10-26-49
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): Slater Mo.

DATE REC'D BY LOCAL REG.: 10-26-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. P. Sheil K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

NOV 22 1949

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 .....

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Charles E Mayfield

Licensed Embalmer No. 4683

P. O. Address K. C. 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.