S. No. 300
v. 10.48

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

FILED AUG 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23961

BIRTH NO. _____ REG. DIST. NO. 181 PRIMARY REG. DIST. NO. 5677 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silex - Rural Union
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Silex, Mo
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silex Rural Union
d. STREET ADDRESS (If rural, give location): 0570

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

4. DATE OF DEATH (Month) (Day) (Year): Aug 3 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 20 1861
9. AGE (In years last birthday): 89 — If under 1 year: Months 2 Days 14 — If under 24 hrs.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Near Annada Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: William Chapman
13b. MOTHER'S MAIDEN NAME: Sara
14. NAME OF HUSBAND OR WIFE: Anda Taylor (Dec.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Horace Steele
ADDRESS: Silex 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) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility — 331X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
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* June 19 49, *to* Aug 1, 1950, *that I last saw the deceased alive on* Aug 1, 1950, *and that death occurred at* 8 4 m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. M. Penn (Degree or title) MD
23b. ADDRESS: Silex Mo.
23c. DATE SIGNED: Aug. 4-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 5 50
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Clarksville Mo

DATE REC'D BY LOCAL REG.: 7/5/50
REGISTRAR'S SIGNATURE: Mrs. J. A. Dwyer 164
25. FUNERAL DIRECTOR'S SIGNATURE: Harvey L. Carroll
ADDRESS: Clarksville Mo

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.

RECEIVED
DISTRICT HEALTH OFFICE No. 4
File No. .....