

FILED OCT 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30681
Registrar's No. 4130

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City 0
c. LENGTH OF STAY (in this place) 4 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: General Hosp. #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Jackson
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City
d. STREET ADDRESS (If rural, give location) 1409 Vine 32680

3. NAME OF DECEASED
a. (First) Josie b. (Middle) Taylor c. (Last) Taylor

4. DATE OF DEATH (Month) (Day) (Year)
Sept. 21, 1950

5. SEX 3
Female

6. COLOR OR RACE
Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Divorced 3

8. DATE OF BIRTH
Aug. 1, 1884

9. AGE (In years last birthday) 66

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
at home

11. BIRTHPLACE (State or foreign country)
Lexington Ky.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13a. FATHER'S NAME
Jal Taylor

13b. MOTHER'S MAIDEN NAME
Maggie Smith

14. NAME OF HUSBAND OR WIFE
unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, N, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.
none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs. Fannie Lucas 1125 Gray

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, ashenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Cerebral Apoplexy
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
Hypertension
Chronicclerosis
DUE TO (a)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE
10 days
351A

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
History from Mrs. Joseph #3

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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE THOS. A. JONES
Thos. A. Jones M.D.

23b. ADDRESS
1617 E 17th

23c. DATE SIGNED
9/28/50

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE
9/30/50

24c. NAME OF CEMETERY OR CREMATORY
Lincoln

24d. LOCATION (City, town, or county) (State)
Kansas City MO.

DATE REC'D BY LOCAL REG.
9-30-50

REGISTRAR'S SIGNATURE
Geraldine Holmes

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
E Sterling Bills 1212 Vine

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

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.....
Student Embalmer

Signed

E. Sterling Kulla

Licensed Embalmer No. *3178*

P. O. Address *1217 Vine St*

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.

K.R.M.