

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1521

FILED JAN 25 1952

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City	c. LENGTH OF STAY (in this place) Unknown	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2		d. STREET ADDRESS (If rural, give location) 1608 1/2 East 12th Street	

3. NAME OF DECEASED (Type or Print) a. (First) Grover	b. (Middle) C.	c. (Last) Taylor	4. DATE OF DEATH (Month) (Day) (Year) 1 2 52
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 3-22-85	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Rob-Roy, Arkansas	12. CITIZEN OF WHAT COUNTRY? America
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13a. FATHER'S NAME William Taylor	13b. MOTHER'S MAIDEN NAME Emily -	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME Lois Owens ADDRESS 1517 East 9th Street
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 490K
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 12-29-51, 19 , to 1-2-52, 19 , that I last saw the deceased alive on 1-2-52, 19 , and that death occurred at 6:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE Frank Ellis MD (Degree or title)	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 1-4-52
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1-5-52	24c. NAME OF CEMETERY OR CREMATORY Luncheon	24d. LOCATION (City, town, or county) (State) K.C. MO
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DATE REC'D BY LOCAL REG. 1-5-52	REGISTRAR'S SIGNATURE Thereldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Billie 1212 ADDRESS K.C. MO
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(Licensed Embalmer's Statement on Reverse Side)

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.....

E. Sterling Bells

Signed.....
Student Embalmer

..... Licensed Embalmer No. *3178*

..... P. O. Address *1213 7th St. S.E. Wash D.C.*

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.