

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3339**  
Registrator's No. **0340**

FILED FEB 2 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>3339</b>		Registrator's No. <b>0340</b>			
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <b>St. Louis Mo.</b> )				c. LENGTH OF STAY (In this place) <b>30 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2109</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3145 New Ashland</b>				d. STREET ADDRESS (If rural, give location) <b>10 3145 New Ashland</b> <b>0</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>Charlie</b>			b. (Middle) _____			c. (Last) <b>Taylor</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>1 9 54</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>8/23/1897</b>		9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (State or foreign country) <b>Shelby County, Tenn.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Charlie Taylor</b>			13b. MOTHER'S MAIDEN NAME <b>Roxie Johnson</b>			14. NAME OF HUSBAND OR WIFE <b>Beatrice Taylor</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NO</b>			17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Roxie Porter, mother 3145 New Ashland</b>					
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Disease</b>						1 yr.	
				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"/>		
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? <b>4201</b>						
22. I hereby certify that I attended the deceased from <b>12-16, 1953</b> , to <b>1-9, 1954</b> , that I last saw the deceased alive on <b>1-9, 1954</b> , and that death occurred at <b>3:00</b> m., from the causes and on the date stated above.											
23a. SIGNATURE <b>G. Sheppard, M.D.</b> (Degree or title)				23b. ADDRESS <b>27022 Franklin</b>				23c. DATE SIGNED <b>1-11-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1/15/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>			24d. LOCATION (City, town, or county) (State) <b>St. Louis, Co Mo.</b>				
DATE REC'D BY LOCAL REG. <b>JAN 18 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Grant Johnson 4352 Washington Blvd.</b>						

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*F. A. Green*

Licensed Embalmer No. ....

*2963*

P. O. Address.....

*4214 Belmont*

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.