

FILED MAY 25 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17315

State File No. _____
Registrar's No. 4176

BIRTH NO. _____		REG. DIST. NO. <u>318</u>	PRIMARY REG. DIST. NO. <u>1003</u>	State File No. _____		Registrar's No. <u>4176</u>
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>13 Yrs.</u>	c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>19 4163 Delmar 219 1/2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Elizabeth</u>		b. (Middle) _____		c. (Last) <u>Taylor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 6, 1954</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>3-25-1899</u>		9. AGE (In years last birthday) <u>55</u> If UNDER 1 YEAR Months _____ Days _____ If UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>La</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James Bynum</u>		13b. MOTHER'S MAIDEN NAME <u>Mary ?</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bennie Glasgow 4015 Maffitt</u>		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Incarcerated Umbilical Hernia</u> ANTECEDENT CAUSES Morbidity 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. <u>Herniorrhaphy with Resection of</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undt</u>
19a. DATE OF OPERATION <u>May 1, 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ileus</u> <u>Incarcerated Umbilical Hernia-Gangrene</u>				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? <u>5612</u>		
22. I hereby certify that I attended the deceased from <u>May 1, 1954</u> , to <u>May 6, 1954</u> , that I last saw the deceased alive on <u>May 6, 1954</u> , and that death occurred at <u>5:40 a.m.</u> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <u>Carl Belle Smith</u>		23b. ADDRESS (M. D.) <u>M. D. 2601 N. Whittier</u>		23c. DATE SIGNED <u>5/6/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>May 10/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		
24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Carl Smith mo F. A. Green 4214 Delmar</u>				
DATE REC'D BY LOCAL REG. <u>MAY 10 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. A. Green 4214 Delmar</u>		

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the ~~body~~ 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.....
Signature of Student Embalmer

Signed *F. A. Green*.....

Licensed Embalmer No. *296*.....

P. O. Address *4214 De la*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.