

FILED AUG 2 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25319

6711

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u>				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MO.</u>			c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>ELKHART</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>BARNES HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) _____				<u>81208</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u>			b. (Middle) <u>Allen</u>		c. (Last) <u>Taylor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 19, 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>April 20, 1885</u>		9. AGE (In years last birthday) <u>69</u> # UNDER 1 YEAR Months _____ # UNDER 2 HRS. Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Elkhart, Illinois</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Cheslea Taylor.</u>			13b. MOTHER'S MAIDEN NAME <u>Sally Allen.</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss. Marjorie Taylor, Virginia, Ill.</u>			ADDRESS _____		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho pneumonia</u>  ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Bladder c metastases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>491X H</u>					
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? _____					
22. I hereby certify that I attended the deceased from <u>June 30, 1954</u> to <u>July 19, 1954</u> that I last saw the deceased alive on <u>July 19, 1954</u> , and that death occurred at <u>10:16 PM</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>H. Bradley</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>BARNES HOSPITAL</u>			23c. DATE SIGNED <u>7/20/54</u>		
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7/20/1954</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION: (City, town, or county) (State) <u>Lincoln, ILLINOIS</u>			
DATE REC'D BY LOCAL REG. <u>JUL 20 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>G.R. Lupton &amp; Sons; 7233 Delmar Blvd</u>				

(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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Clarence H. Murray*

Licensed Embalmer No. *49*

P. O. Address *St. Louis*

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.