

FILED APR 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10275**
Registrar's No. **2882**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location)		2119 2509 North Taylor	
3. NAME OF DECEASED (Type or Print) a. (First) Clara		b. (Middle) Nelson		c. (Last) Taylor	
4. DATE OF DEATH (Month) (Day) (Year) 3 27 55		5. SEX F		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 9, 1904		9. AGE (in years last birthday) 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Cassett, Arkansas	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Daniel Taylor		13b. MOTHER'S MAIDEN NAME Anne Turner	
14. NAME OF HUSBAND OR WIFE David Nelson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Fannie Mae Johnson		ADDRESS 4032 Labadie		18. CAUSE OF DEATH	
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) Hypertension; Diabetes Mellitus 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. Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH Undt.			
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)	
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? 260X	
22. I hereby certify that I attended the deceased from 3-19 , 19 55 , to 3-27 , 19 55 , that I last saw the deceased alive on 3-27 , 19 55 , and that death occurred at 5:00 A.m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Edw. B. Williams		23b. ADDRESS M.D. 2601 N. Whittier		23c. DATE SIGNED 3-28-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE April 4, 1955		24c. NAME OF CEMETERY OR CREMATORY Greenwood	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		DATE REC'D BY LOCAL REG. MAR 30 1955		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Mrs. B. Kosuce		ADDRESS 1221 N. Grand			

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 *Gayton Swan*.....

Licensed Embalmer No. *458*.....

P. O. Address *1221 N. D.*.....

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.