

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31656

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7517

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 township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hospital		STREET ADDRESS (If rural, give location) 22 2621 Walnut Street	

3. NAME OF DECEASED (Type or Print) Raymond (Robert Taylor)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 8 24 55
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 8-3-1907	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Tennessee		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME John White	13b. MOTHER'S MAIDEN NAME Louella Curry	14. NAME OF HUSBAND OR WIFE
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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 Leslie White	ADDRESS 1523 Laffin
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Alcoholism with Delirium Tremens		
	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 307X	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)
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?

22. I hereby certify that I attended the deceased from 8-21 1955, to 8-24 1955, that I last saw the deceased alive on 8-24 1955, and that death occurred at 12:50 p. m., from the causes and on the date stated above.

23a. SIGNATURE E. B. Williams	(Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 8-25-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug 24, 1955	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
DATE REC'D BY LOCAL REG. AUG 29 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE E. B. Koonce 12217 Grand	

(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.....

Guyton Swan

Licensed Embalmer No. *458*

P. O. Address *1221 1/2*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.