

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40740

FILED JAN 4 1957

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY <b>Butler</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Butler</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Poplar Bluff</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>West Plains, Mo.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Doctors Hospital</b>			Length of stay in lb <b>2 days</b>		d. STREET ADDRESS <b>R R # 3</b>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>SHIRLEY MAY TAYLOR</b>				First	Middle	Last	4. DATE OF DEATH <b>12-23-1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-6-1937</b>		9. AGE (In years last birthday) <b>19</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Vernon A. Mills</b>				14. MOTHER'S MAIDEN NAME <b>Leona Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Walter B. Taylor West Plains, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glomerulonephritis, chronic with acute exacerbation.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c)	19. WAS AUTOPSY PERFORMED? <b>592X</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Poplar Bluff, Mo.</b>		COUNTY	STATE
21. I attended the deceased from <b>12-18-56</b> to <b>12-23-56</b> and last saw <sup>her</sup> / <sub>him</sub> alive on <b>12-23-56</b> Death occurred at <b>1:28 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Robert Chugelhardt MD.</b>				22b. ADDRESS <b>Poplar Bluff, Mo.</b>		22c. DATE SIGNED <b>1/3/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-23-56</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>West Plains, Mo.</b>		(State)
24. FUNERAL DIRECTOR <b>Robertson Funeral Home W. Plains, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>12/29/56</b>		26. REGISTRAR'S SIGNATURE <b>RH Muehle</b>		

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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RECEIVED  
DEC 31 1956  
BUTLER CO. HEALTH CENTER  
FILE No. \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ray Pridame  
Licensed Embalmer No. 49

P. O. Address Point B

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