

FILED JUN 10 1957

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 103

300
1-56

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Saline ✓	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall		c. CITY OR TOWN Marshall	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bufford Rest		d. STREET ADDRESS Marion St.	
Length of stay in 1b Home		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Eva Belle Taylor			4. DATE OF DEATH June 6 - 1957		
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/1899	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 10 Days 28 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) invalid		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Saline County, Mo.	12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME Edward Taylor			14. MOTHER'S MAIDEN NAME Sophie Henderson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Lacy Asbury, Slater, Mo.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vas Accident (Stroke)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 _____ 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 COUNTY STATE

21. I attended the deceased from June 6 to June 6 and last saw her alive on June 6
Death occurred at 10:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) D. K. Kumpeneck	22b. ADDRESS Marshall Mo.	22c. DATE SIGNED 6/8
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 8, 1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Slater, Mo.
24. FUNERAL DIRECTOR ADDRESS Hill Brothers, Slater, Mo.	25. DATE RECD. BY LOCAL REG. 6-8-57	26. REGISTRAR'S SIGNATURE Carl Y. Reed	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *A. C. Hill*

Licensed Embalmer No. *30*

P. O. Address *State*

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.