

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19869

FILED MAY 20 1957

STATE FILE NUMBER

Registration District No. 357 Primary Registration District No. 4526 Registrar's No. 3

300
-57

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>VERNON</u> <input checked="" type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHELDON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SHELDON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NONE</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>1080</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>DELLA JOSEPHINE TAYLOR</u>			4. DATE OF DEATH Month Day Year <u>MAY 6 57</u>		
--	--	--	--	--	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-1882</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
----------------------	----------------------------	--	----------------------------------	---	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>ELLSWORTH KANS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>
--	---	--	---

13a. FATHER'S NAME <u>ELI. MEEK</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH MEEK</u>	14. NAME OF HUSBAND OR WIFE <u>ARLIE TAYLOR</u>
-------------------------------------	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>ARLEY TAYLOR SHELDON MO.</u>
---	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>421</u>		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 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.) <u>LAMAR</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Benton MO</u>
---	--	---	--

21. I attended the deceased from <u>February 1952</u> to <u>April 20</u> and last saw her alive on <u>April 20-57</u> Death occurred at <u>2:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE <u>D R Guelaner</u> (Degree or title)	22b. ADDRESS <u>LAMAR</u>	22c. DATE SIGNED <u>5.6.57</u>
--	---------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>MAY 6-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MARIAN</u>	23d. LOCATION (City, town, or County) (State) <u>KANSAS CITY MO</u>
--	---------------------------	--	---

24. FUNERAL DIRECTOR <u>Beeny Funeral Home, Sheldon</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>May 13 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ruth Faith</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300

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 *L. Gerald Beamy*

Licensed Embalmer No. *4203*
P. O. Address *Shelburne*

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.