

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20242

State File No. \_\_\_\_\_

Registrar's No. 389

No. 300  
10-48

FILED JUN 20 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Butler</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u> |  | c. CITY OR TOWN <u>Essex</u>   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place)  |  | e. STREET ADDRESS (If rural, give location) <u>1030</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Poplar Bluff Hospital</u>                             |  |  |   |

|                                     |                           |                       |                         |   |
|-------------------------------------|---------------------------|-----------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>William</u> | b. (Middle) <u>R.</u> | c. (Last) <u>Taylor</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 31, 1957</u> |
|-------------------------------------|---------------------------|-----------------------|-------------------------|---|

|                    |                               |   |                                       |  |
|--------------------|-------------------------------|---|---------------------------------------|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Nov. 18, 1880</u> | 9. AGE (In years if under 1 year last birthday) (Months) (Days) (Hours) (Min.) <u>76-6-0-16-13</u> |
|--------------------|-------------------------------|---|---------------------------------------|--|

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Stoddard County, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
|---|-----------------------------------|--|--|

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME <u>William R. Taylor</u> | 13b. MOTHER'S MAIDEN NAME <u>Martha Rhodes</u> | 14. NAME OF HUSBAND OR WIFE <u>Mary C. Taylor</u> |
|---|--|---|

|   |                               |   |                           |
|---|-------------------------------|---|---------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mary C. Taylor,</u> | ADDRESS <u>Essex, Mo.</u> |
|---|-------------------------------|---|---------------------------|

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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 |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Circulatory Heart Disease</u>  |  |                                  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Atherosclerosis, Systemic</u><br>DUE TO (c) <u>Pulmonary Fibrosis</u> |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |                                  |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>4201</u> | 20. AUTOPSY? <u>2</u><br>YES <input type="checkbox"/> NO <input checked="" 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) 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 5-30-57, to 5-31, 1957, that I last saw the deceased alive on 5-31, 1957, and that death occurred at 9:20 Pm., from the causes and on the date stated above.

|  |                                       |                                 |
|--|---------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Dexter E. Mueller M.D.</u> | 23b. ADDRESS <u>Poplar Bluff, Mo.</u> | 23c. DATE SIGNED <u>6-10-57</u> |
|--|---------------------------------------|---------------------------------|

|   |                         |  |   |
|---|-------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>6-2-57</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Dexter</u> | 24d. LOCATION (City, town, or county) (State) <u>Dexter, Missouri</u> |
|---|-------------------------|--|---|

|   |  |   |                            |
|---|--|---|----------------------------|
| DATE REC'D BY LOCAL REG. <u>6/12/57</u> | REGISTRAR'S SIGNATURE <u>D E Mueller</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Strickland-Rainey</u> | ADDRESS <u>Dexter, Mo.</u> |
|---|--|---|----------------------------|

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

890

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

JUN 17 1957

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 embalmed

by me, ~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision..

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

Signed \_\_\_\_\_

Licensed Embalmer No. 498

P. O. Address Butler, Pa.

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.