Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-034750

STATE FILE NUMBER

FILED OCT 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9411

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes [X] No [ ]

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL — Length of stay in 1b 04

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY Peoria

c. CITY OR TOWN East Peoria 8129 — Inside Limits Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location) 118 Edmund St — Reside on Farm Yes [ ] No [X] 32

3. NAME OF DECEASED (Type or print) First OLLIE Middle BERNICE Last TAYLOR

4. DATE OF DEATH Month Day Year SEPTEMBER 29, 1958

5. SEX Female

6. COLOR OR RACE White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH March 24.1914

9. AGE (In years last birthday) 44 — 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) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Aurora Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Fred Watkins

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Chriss Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Chriss Taylor Address East Peoria Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION ?

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) RIGHT UPPER LOBECTOMY — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

DUE TO (c) PULMONARY TUBERCULOSIS .002x — 1 YEAR

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 [ ] NO [X] 21

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 SEPT. 22, 1958, to SEPT. 29, 1958 and last saw her/him alive on SEPT. 29, 1958

Death occurred at 3:05 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. D. Vermillion, M.D. M. D.

22b. ADDRESS BARNES HOSPITAL

22c. DATE SIGNED 9/29/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 9-30-58

23c. NAME OF CEMETERY OR CREMATORY Local

23d. LOCATION (City, town, or county) (State) East Peoria Ill

24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington

25. DATE RECD. BY LOCAL REG. OCT 1 '58

26. REGISTRAR'S SIGNATURE J Carl Smith M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed J Wm Bunsley
Signature of Student Embalmer

Licensed Embalmer No. 3653

P. O. Address St Louis

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.