

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008581

STATE FILE NUMBER

FILED APR 10 1959

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 61

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, or institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>Buckley</u> )	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Poplar Bluff</u> <u>0120</u> <u>0</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print) First <u>Janie</u> Middle <u>Taylor</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>August 22, 1891</u>
9. AGE (In years less birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Preacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religion</u>	11. BIRTHPLACE (City and state or country) <u>Campbell, Missouri</u>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>Charlie Brown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Della Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Della Taylor</u> Address <u>Poplar Bluff, 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>Acute toxic myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Ascending diabetic gangrene</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>2 wks.</u> <u>Unknown</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 <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	
20d. INJURY OCCURRED WHILE AT <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 <u>1 Dec 58</u> to <u>13 Jan 59</u> and last saw her alive on <u>6 Jan 59</u> Death occurred at <u>about 2 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Cyril A. Post M.D.</u>		22b. ADDRESS <u>Poplar Bluff, Mo.</u>	22c. DATE SIGNED <u>14 Jan 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/14/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Manila Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Manila, Miss. Co., Arkansas</u>
24. FUNERAL DIRECTOR <u>W. E. McMath - Swift Funeral Home</u> ADDRESS <u>Osceola, Ark</u>		25. DATE RECD. BY LOCAL REG. <u>1/31/59</u>	26. REGISTRAR'S SIGNATURE <u>L.H. Muehree</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which are causally related. All diseases in Part I must be causally related.

RECEIVED

APR 8 1959

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

APR 10 1959

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. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.