

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014064

STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 115-

300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Chula</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR NURSING HOME INSTITUTION <u>503-2nd St</u>		Length of stay in 1b <u>2 Weeks</u>	d. STREET ADDRESS (If outside, give location) <u>✓</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lemuel</u> Middle <u>C</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 16 1867</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber-Grocery</u>	11. BIRTHPLACE (City and state or country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Samuel C Taylor</u>		13b. MOTHER'S MAIDEN NAME <u>Maride Hudson</u>		14. NAME OF HUSBAND OR WIFE <u>Mary 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>Sigval Nelsen</u> Address <u>Chula, 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>GASTRIC HEMORRHAGE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CHRONIC MYOCARDITIS</u>					<u>7 yrs.</u>
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>9 4222</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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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>Aug 1954</u> to <u>Apr 26 1959</u> and last saw ^{her} <u>him</u> alive on <u>Apr 25 1959</u> Death occurred at <u>6:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Thomas L. Malaga DO.</u>			22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>4/27/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 28 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Plainview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chula Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>E.J. Robertson Funeral Home - Chula Mo</u>			25. DATE RECD. BY LOCAL REG. <u>4/27/59</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>	

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 *J. M. Plecton*

Licensed Embalmer No. *4388*
P. O. Address. *Laredo Mo*

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.