

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020593

FILED JUL 15 1959

Registration District No. 17 Primary Registration District No. 3008 Registrar's No. 190

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Warren	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		Length of stay in 1b 15 days	c. CITY OR TOWN Warrenton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #1		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 407 West Main Street Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Muriel Middle Taylor Last Taylor			4. DATE OF DEATH Month July Day 8 Year 1959			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1909	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Porter Taylor		13b. MOTHER'S MAIDEN NAME Nettie Prentice		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT State Hospital No. 1, Fulton, Mo. Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome due to Cerebral Arteriosclerosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. Attended the deceased from **xx St. Hosp. June 23, 1959** to **July 8, 1959** and last saw her/him alive on **July 8, 1959**
Death occurred at **10:15 a.m.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Erwin Leonhardt, M.D.	22b. ADDRESS St. Hospital No. 1	22c. DATE SIGNED 7-8-59
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	23b. DATE 7-11-59	23c. NAME OF CEMETERY OR CREMATORY WARRENTON CEMETERY	23d. LOCATION (City, town, or county) (State) WARRENTON MO.
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24. FUNERAL DIRECTOR Marpin Funeral Home, Fulton, Mo.	25. DATE RECD. BY LOCAL REG. 15 July 1959	26. REGISTRAR'S SIGNATURE Martha Lawrence
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 15 1959

AUG 24 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Marshall C. Black

Licensed Embalmer No. 4713

P. O. Address Fulton, Y.

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.