

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020717

STATE FILE NUMBER

FILED JUL 6 1959 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <b>Clay</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Excelsior Springs</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ex.Spgs.Hospital</b>			Length of stay in lb <b>4/30/59</b>	d. STREET ADDRESS (If outside, give location) <b>525 Kansas City Ave</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>H.</b> Last <b>Taggart</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> , Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1885</b>	9. AGE (In years last birthday) <b>74</b>	F UNDER 1 YEAR Months <b>1</b> Days <b>6</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>XXXXX</b>		11. BIRTHPLACE (City and state or country) <b>Carrollton, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>W.H. Winfrey</b>			13b. MOTHER'S MAIDEN NAME <b>Ophelia Walling</b>		14. NAME OF HUSBAND OR WIFE <b>Frank G. Taggart</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No.</b>	17. INFORMANT Address <b>Frank G. Taggart, Wichita, Kansas</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of gall bladder with metastasis to liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>1551</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>5/12/59-operated by Dr. Wallace Greene- nothing removed.</b>						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.							
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. I attended the deceased from <b>4/28/59</b> to <b>6/12/59</b> and last saw him alive on <b>6/12/59</b> Death occurred at <b>10.00 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>M. D. Excelsior Springs, Mo.</i>				22b. ADDRESS <b>M. D. Excelsior Springs, Mo.</b>		22c. DATE SIGNED <b>6/15/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Excelsior Springs, MO.</b>		
24. FUNERAL DIRECTOR <b>Virgil Hope</b>			ADDRESS <b>Ex.Spgs.MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6/20/59</b>	26. REGISTRAR'S SIGNATURE <i>Baroline Hutchings</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.



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 *Chas. Virgil Hope* .....

Licensed Embalmer No. *3950* .....

P. O. Address *Eschscholtz Sp...*

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.