

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030837

FILED VS AUG 18 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7227** STATE FILE NUMBER \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b _____	c. CITY OR TOWN <b>St. Louis</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>Enroute City Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2726 Bernard St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle _____ Last <b>Taylor</b>	4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1959</b>
--	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/25/1913</b>	9. AGE (last birthday) <b>45</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR. Hours _____ Min. _____
--------------------	-------------------------------	--	-----------------------------------	----------------------------------	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Sodding Co.</b>	11. BIRTHPLACE (City and state or country) <b>Warrenton, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
---	--	--	---

13a. FATHER'S NAME <b>Porter Taylor</b>	13b. MOTHER'S MAIDEN NAME <b>Nettie Prentis</b>	14. NAME OF HUSBAND OR WIFE <b>Allie Mae</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Maybelle Taylor, 2736 Dayton St.</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>Traumatic External Hemorrhage contrib: stab wound of Jugular Vein.</b>		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) <b>Suffered when stabbed with knife driven by the hands of one Estella J. Summers (rel)</b>	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
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18) <b>stabbed with knife driven by the hands of one Estella J. Summers (rel)</b>
20c. TIME OF INJURY <b>1040 p.m.</b> Hour _____ Month, Day, Year <b>8 25 59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>
	20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>	COUNTY _____ STATE _____

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw him/her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m. of the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Earl Taylor</b> (Degree or title) _____	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>8/4/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-6-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>
	23d. LOCATION (City, town, or county) <b>Warrenton, Mo.</b>	(State) _____

24. FUNERAL DIRECTOR <b>F.W. Nieburg &amp; Co., Warrenton, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 4 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*John J. Hain*  
Licensed Embalmer No. 4108

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.