

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034389

FILED VS OCT 8 1959

2 8990

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b _____		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1382 Clara Ave</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Husbell</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</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>Dec. 8, 1915</u>	9. AGE (last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>9</u> Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Oxford Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.A.</u>		
13a. FATHER'S NAME <u>William Mc Glows</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie Harris</u>			14. NAME OF HUSBAND OR WIFE <u>Mr. M. Bee Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>500-20-4559</u>		17. INFORMANT Address <u>Mr. M. Bee Taylor 1382 Clara Ave</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>Uremia</u> DUE TO (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>600.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 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 <u>Sept 18, 59</u> to <u>Sept. 27, 1959</u> and last saw her <u>alive on Sept 27, 1959</u> Death occurred at <u>6:00 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>J. Howard M.D.</u> (Degree or title)				22b. ADDRESS <u>5593 Carew Rd</u>		22c. DATE SIGNED <u>9-27-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Oct. 2-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>				
24. FUNERAL DIRECTOR <u>Herman J. Smith 4247/ Labadie Ave</u>				25. DATE RECD. BY LOCAL REG. <u>SEP 30 59</u>		26. REGISTRAR'S SIGNATURE <u>Loard Smith M.D.</u> <u>S.P.</u>			

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *H. Clark Gordon*

Licensed Embalmer No. 3159

P. O. Address 1123 71/1st

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.