

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012157

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 764

AMENDED

FILED MAR 27 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

| | | | |
|---|---|--|--|
| 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> COUNTY <u>St. Louis.</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City, Mo.</u> | | Length of stay in 1b <u>8 yrs.</u> | c. CITY OR TOWN <u>University City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>503 Warren</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>503 Warren</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Gail</u> Middle Last <u>Taylor</u> | | | 4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1961</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/31/1881</u> |
| | | 9. AGE (last birthday) <u>79</u> | 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) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Sparta, Illinois.</u> |
| | | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>S. Lovejoy Taylor</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Caudle</u> | 14. NAME OF HUSBAND OR WIFE <u>Nil.</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>Nil.</u> | 17. INFORMANT Address <u>Mable McQuiston, 503 Warren</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>Coronary Disease of Heart</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) 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 | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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>3-15-61</u> to <u>3-19-61</u> and last saw her ^{her} _{him} alive on <u>3-19-61</u> Death occurred at <u>7:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Samuel W. Vermeulen</u> | | 22b. ADDRESS <u>634 1/2 Grand Ave</u> | 22c. DATE SIGNED <u>3-20-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>3-20-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Caledonia Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Sparta, Ill</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe Inc., 4700 Washington,</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-20-61</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</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

John Binkley

Licensed Embalmer No. 365

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.