MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3140 -63-013910
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED MAR 28 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4022a N. Market St.,
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Ella Middle Last Tayler

4. DATE OF DEATH: Month 3 Day 14 Year 63

5. SEX: Fem.

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: Unk

9. AGE (last birthday): Abt. 71

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): Nil

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Mississippi

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of servi

16. SOCIAL SECURITY NO.

17. INFORMANT: Debert Burtington Address: 5744 Clemons-Apt. 2-W

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Electrolyte Imbalance — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Dehydration 570.5
DUE TO (c): Partial Intestinal Obstruction

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Arteriescleretic Heart Disease with Atrial Fibrillation

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 3-12-63 to 3-14-63 and last saw her alive on 3-14-63
Death occurred at 11:58 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

22b. ADDRESS: 2601 N. Whittier

22c. DATE SIGNED: 3-15-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 3-19-63

23c. NAME OF CEMETERY OR CREMATORY: Oakdale Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.,

24. FUNERAL DIRECTOR: G. Wade Granberry ADDRESS: 4202 Finney Ave.,

25. DATE RECD. BY LOCAL REG.: MAR 18 1963

26. REGISTRAR'S SIGNATURE: Joan Smith, M.D.

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 Edward a. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.,

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.