

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-040765

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 70

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 14 1963

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Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY NEWTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY NEWTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN STELLA		c. CITY OR TOWN STELLA	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CARDWELL MEMORIAL HOSP		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First CARRIE Middle C. Last TAYLOR		4. DATE OF DEATH Month OCTOBER Day 27 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) Claiborne Co. Tenn. USA
13a. FATHER'S NAME STERLING WOLFE		13b. MOTHER'S MAIDEN NAME RACHELL WALKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Mrs Ray Peters	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: - IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Cerebral sclerosis DUE TO (c) advanced arteriosclerosis		14. NAME OF HUSBAND OR WIFE ROBERT TAYLOR (Deceased)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		12. CITIZEN OF WHAT COUNTRY USA	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour 2:58 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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.)	
21. I attended the deceased from 1962 to Oct 27/63 and last saw her alive on Oct 27, 63		22c. DATE SIGNED 10/30/63	
22a. SIGNATURE D. Fountain (Degree or title)		22b. ADDRESS noel mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-29-63	
23c. NAME OF CEMETERY OR CREMATORY Macedonia Cem.		23d. LOCATION (City, town, or county) Stella, Missouri	
24. FUNERAL DIRECTOR W. Morris Pope		25. DATE RECD. BY LOCAL REG. 11-4-63	
26. REGISTRAR'S SIGNATURE Mildred Moberly			

USE BLACK INK OR TYPEWRITER RIBBON

Faint, mostly illegible text at the top of the page, possibly containing a header or form fields.

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: Wm Morris Pojue

Licensed Embalmer No. 3443
P. O. Address Wheaton Mo.

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.