

FILED JUL 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

223134  
State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 45-135 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>Milan</u> d. STREET ADDRESS (If rural, give location) _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Milan</u> c. LENGTH OF STAY (in this place) <u>77 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Milan</u> d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary Maurey</u>	b. (Middle) <u>Jane</u>	c. (Last) <u>Porter</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6</u> <u>16</u> <u>1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-27-1871</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR <u>8</u> Months <u>13</u> Days	IF UNDER 2 HRS. <u>0</u> Hours <u>0</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer wife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Sullivan Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>John McNealey</u>	13b. MOTHER'S MAIDEN NAME <u>Virginia</u>	14. NAME OF HUSBAND OR WIFE <u>Reece Porter</u>
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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. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Reece Porter</u>	ADDRESS <u>Milan Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>not known</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerosis resulting in vascular accidents.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u> <u>diabetes mellitus</u>		45'00	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 1948, to June 11, 1949, that I last saw the deceased alive on June 8, 1949, and that death occurred at 3:15 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. S. Montgomery M.D.</u>	23b. ADDRESS <u>Milan Mo.</u>	23c. DATE SIGNED <u>6-16-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6-13-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oakwood - Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Milan</u> <u>Mo</u>
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DATE REC'D BY LOCAL REG. <u>July 1-1949</u>	REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Schoenle</u>	ADDRESS <u>Sugar Creek</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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JAN 9 1957

RECEIVED:

District Health Officer No. 1

State File Number 2-49-1

Date Filed JUL 5 1949

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 \_\_\_\_\_

D. Norris Cleeton

Student Embalmer No. 238

working under my personal supervision.

Signed

D. Norris Cleeton

Student Embalmer

Signed

Dwight Schorn

Licensed Embalmer No. 21067

P. O. Address

Windsor - Wis

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 this body is not embalmed, fact should be so stated above.