

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39172

State File No. 10465

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Jacobs	
d. STREET ADDRESS n.p.		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Bernice		b. (Middle) 0	
c. (Last) Porter		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH May 3, 1909		9. AGE (In years last birthday) 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Jacobs, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Julius J. Schmitt		13b. MOTHER'S MAIDEN NAME Bertha Hug	
14. NAME OF HUSBAND OR WIFE Barney Porter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 331-16-6538		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Julius Schmitt, St. Jacobs, Ill.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of sigmoid with metastasis to liver ANTECEDENT CAUSES Morbidity 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 462	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 153X		22. I hereby certify that I attended the deceased from Nov. 27, 1949 , to Dec. 1, 1949 , that I last saw the deceased alive on Dec. 1, 1949 , and that death occurred at 3:30 pm. , from the causes and on the date stated above.	
23a. SIGNATURE HR Bradley		23b. ADDRESS Barnes Hospital	
23c. DATE SIGNED 12/5/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 12-5-49		24c. NAME OF CEMETERY OR CREMATORY Ketstone	
24d. LOCATION (City, town, or county) (State) St. Jacobs, Ill.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
DATE REC'D BY LOCAL REG. DEC 5 1949		REGISTRAR'S SIGNATURE J. B. Pasater	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300
48

STATEMENT BY LICENSED EMBALMER

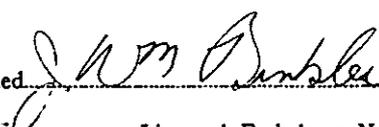
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

....., Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No.

3653

P. O. Address

St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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