

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32307

32307

0970
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. 323 PRIMARY REG. DIST. NO. 4474 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY SALINE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY PETTIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SWEET SPRINGS		c. CITY (If outside corporate limits, write RURAL and give township) RURAL 0800	
c. LENGTH OF STAY (in this place) 30 DAYS		d. STREET ADDRESS (If rural, give location) 10MI-S.W. of SWEET SPRINGS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 110 N. MULBERRY			
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) FRANCES c. (Last) PORTER		4. DATE OF DEATH (Month) (Day) (Year) Sept-23-50	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH July-16-1881
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) JOHNSON COUNTY, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME GEORGE W. PORTER		13b. MOTHER'S MAIDEN NAME SARAH MARSHALL	
14. NAME OF HUSBAND OR WIFE ERNEST L. PORTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME Ernest L. Porter		P.R. ADDRESS Knob Knoster, Mo	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis - generalized ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary ca pancreas DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus	
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) (m.)		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 8 Mv 1949 , to 23 Sept, 1950 , that I last saw the deceased alive on 9-22, 1950 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Ralph A. Jones M.D.		23b. ADDRESS Sweet Springs, Mo.	
23c. DATE SIGNED 23 Sept 50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9-25-50	
24c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		24d. LOCATION (City, town, or county) (State) PETTIS COUNTY, Mo.	
DATE REC'D BY LOCAL REG. 9/25/50		REGISTRAR'S SIGNATURE 298	
25. FUNERAL DIRECTOR'S SIGNATURE Dally Anderson		ADDRESS L. F. Parker - Sweet Springs, Mo	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 1/2/30
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 1/2/30

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.

Signed _____
Student Embalmer

Signed L. F. Parker

Licensed Embalmer No. 3840

P. O. Address Sweet Springs, N.C.

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.