

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44214

FILED FEB 2 1952

State File No. 0667
Registrar's No. 627

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) St Louis		b. COUNTY 4119
d. FULL NAME OF HOSPITAL OR INSTITUTION 4353 Maffett			d. STREET ADDRESS (If rural, give location) 4353 Maffett		
3. NAME OF DECEASED (Type or Print) Phillips C Porter		a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 12-28-51
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH abt. 80	9. AGE (In years last birthday) F UNDER 1 YEAR Months Days F UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Clark		13b. MOTHER'S MAIDEN NAME Clark		14. NAME OF HUSBAND OR WIFE Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year or unknown) (If yes, state year or dates of service) Clark		16. SOCIAL SECURITY NO. Clark	17. INFORMANT'S SIGNATURE OR NAME ADDRESS R. Taylor Croner 1300 Clark		
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) <u>Cerebral apoplexy</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.			INTERVAL BETWEEN ONSET AND 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)		
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? 334X		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:09 Pm., from the causes and on the date stated above.					
23a. SIGNATURE Joseph M. Quinn Deputy Coroner			23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1/15/52
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE JAN 22 1952	24c. NAME OF CEMETERY OR CREMATORY Anthonia Boro	24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. JAN 22 1952		REGISTRAR'S SIGNATURE Paul Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service	

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

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.....

Students of Mortuary College

working under my personal supervision.

Student Embalmer No.....

Signed..... *James A. Sammers*

Signed.....
Student Embalmer

Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

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.