

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12171**

FILED APR 110 1953

BIRTH NO. **39150**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **3336**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (in this place) 10 mo	
c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer B. Phillips		d. STREET ADDRESS (If rural, give location) 21 815 N. 20th Street	
3. NAME OF DECEASED (First) PAMELA (Type or Print) Pamela		b. (Middle)	
c. (Last) PORE		4. DATE OF DEATH (Month) (Day) (Year) 3 25 53	
5. SEX F 3	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5-21-1952
9. AGE (in years last birthday) 10		10. AGE (in years) if under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME John Pore		13b. MOTHER'S MAIDEN NAME Beatrice Harris	
14. NAME OF HUSBAND OR WIFE		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. no		17. INFORMANT'S SIGNATURE OR NAME Beatrice Harris	
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) Acute Bronchitis 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.	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 500X		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 3:30 a. m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Alfred Pore		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 3/30/53		24a. BURIAL, CREMATION, REMOVAL (Specify) 3-30-53	
24b. DATE 3-30-53		24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery	
24d. LOCATION (City, town, or county) (State) Lenexa MO.		25. FUNERAL DIRECTOR'S SIGNATURE Gus Lowe	
25. ADDRESS 2930 Dickson, St.		DATE REC'D BY LOCAL REG. MAR 30 1953	
REGISTRAR'S SIGNATURE Charles Smith		25. ADDRESS 2930 Dickson, St.	

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 Arthur L. Herliard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldene

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.