

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20781**

FILED JUL 6 - 1953

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **729**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Mo. Meth. Hospital		d. STREET ADDRESS (If rural, give location) 6635 Washington St.	

3. NAME OF DECEASED (Type or Print) a. (First) VERA b. (Middle) MAY c. (Last) PORTER			4. DATE OF DEATH (Month) (Day) (Year) 6 27 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-11-1911	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work including most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Forrest City, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME James Lease	13b. MOTHER'S MAIDEN NAME Maude Wallace	14. NAME OF HUSBAND OR WIFE Opal O. Porter
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME City ADDRESS Opal O. Porter, 6635 Washington St.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis		DUPLICATE (b) and Partial Intestinal obstruction		4 da.
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE (c) Paralytic Ileus		2 da.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Anemia - Lypochromic		2 da.

19a. DATE OF OPERATION 6-22-53	19b. MAJOR FINDINGS OF OPERATION Blood transfusion 6.20.53 Fibromyomata uteri; Polycystic Ovary	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? 214X

22. I hereby certify that I attended the deceased from **6-9, 1953** to **6-27, 1953**, that I last saw the deceased alive on **6-27, 1953** and that death occurred at **9:40P** m., from the causes and on the date stated above.

23a. SIGNATURE E. Grant M.D. (Degree or title)	23b. ADDRESS St. Joseph, Mo.	23c. DATE SIGNED 6-29-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-29-1953	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. July 3, 1953	REGISTRAR'S SIGNATURE Ethel M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE John Ruppert ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

John C. Rupp
Licensed Embalmer No. 3986
P. O. Address St. Joseph, Mo.

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.