

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**11630**

State File No. ....

No. 300  
10-48

**FILED MAY 11 1954**

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>5390</u>		Registrar's No. <u>30</u>	
1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>			
b. CITY OR TOWN <u>Rural Springcreek</u>		c. LENGTH OF STAY (In this place) <u>10 yrs</u>		c. CITY OR TOWN <u>Rural</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home 4 mi. west 32 hiwa</u>				e. STREET ADDRESS (If rural, give location) <u>Rural 4 mi west 32 hiwa,</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Cora</u>		b. (Middle) <u>Belle</u>		c. (Last) <u>Black</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 4 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Married</u> (Specify)		8. DATE OF BIRTH <u>Oct 6-1890</u>	
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Shannon county mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13a. FATHER'S NAME <u>Tince Wells</u>		13b. MOTHER'S MAIDEN NAME <u>Inez Hardcastle</u>		14. NAME OF HUSBAND OR WIFE <u>Porter Black</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Porter Black</u>		ADDRESS <u>Salem Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant Melanoma</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
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) <u>190X</u>			
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 <u>June 53</u> to <u>May</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>54</u> , and that death occurred at <u>10 A.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ray E Mitchell M.D.</u>				23b. ADDRESS <u>Salem Mo</u>		23c. DATE SIGNED <u>5/5/54</u>	
24a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>buried</u>		24b. DATE <u>5-6-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cedargrove</u>		24d. LOCATION (City, town, or county) (State) <u>Salem Mo.</u>	
DATE REC'D BY LOCAL REG. <u>5-6-54</u>		REGISTRAR'S SIGNATURE <u>M. Hart, M.D. by Mrs</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Spencer</u>		ADDRESS <u>Salem Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

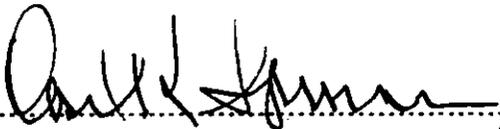
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0230

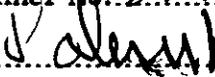
**STATEMENT BY LICENSED EMBALMER**

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.....  
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 237

P. O. Address 

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.