

STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 517 PRIMARY REG. DIST. NO. 547

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR <u>TOWN Richmond Heights</u>		c. CITY OR TOWN <u>Collinsville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>2 Days</u>		• STREET ADDRESS (If rural, give location) <u>801 Cedar Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Mary's Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>EDWARD</u>	b. (Middle) <u>JACOB</u>	c. (Last) <u>PORTZ</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 5, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 10, 1892</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ins. and real estate</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Troy, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Henry Portz</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Steinkoenig</u>	14. NAME OF HUSBAND OR WIFE <u>Matilda Portz</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>- 357-10-8030</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ed. Portz</u>	ADDRESS <u>Collinsville, Ill.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain tumor</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.			

19a. DATE OF OPERATION <u>8/3/54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Tumor of pt. temporal and frontal lobes</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug. 2, 1954, to Aug. 5, 1954, that I last saw the deceased alive on Aug. 5, 1954, and that death occurred at 4:30 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Paul John Retter M.D.</u>	23b. ADDRESS <u>St. Mary's Hospital</u>	23c. DATE SIGNED <u>Aug. 5, 1954</u>
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>Aug. 8, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. John's Black Jack</u>	24d. LOCATION (City, town, or county) (State) <u>Troy, Ill.</u>
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DATE REC'D BY LOCAL REG. <u>8/6/54</u>	REGISTRAR'S SIGNATURE <u>Richard B. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Froman</u>	ADDRESS <u>Collinsville, Ill.</u>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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**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 *Paul Froman*.....

Licensed Embalmer No.....

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.