

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2211**
Registrar's No. **37**

FILED JAN 17 1955

BIRTH NO.		REG. DIST. NO. 310	PRIMARY REG. DIST. NO. 2068
1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) St. Charles	c. LENGTH OF STAY (In this place) 2 weeks	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles 0923	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital	d. STREET ADDRESS (If rural, give location) ----- 0		
3. NAME OF DECEASED (Type or Print) a. (First) Helen	b. (Middle) -----	c. (Last) Portzig	4. DATE OF DEATH (Month) (Day) (Year) Jan 4 1955
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Jan. 26 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Housework	9. AGE (In years last birthday) 77 # UNDER 1 YEAR Months --- # UNDER 1 HR. Hours --- Min. ---	
13a. FATHER'S NAME William Portzig	13b. MOTHER'S MAIDEN NAME not known	11. BIRTHPLACE (State or foreign country) St. Charles Co. Mo. 0	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. none	12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT'S SIGNATURE OR NAME Rev. Glen Jones		ADDRESS St. Charles, Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Ovary INTERVAL BETWEEN ONSET AND DEATH 4 years ANTECEDENT CAUSES Morbidity 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 1951	19b. MAJOR FINDINGS OF OPERATION Carcinoma of Ovary		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)	
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 Feb 17, 1954 , to Jan 4, 1955 , that I last saw the deceased alive on Jan 4, 1955 , and that death occurred at 10:15 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. A. Rewis M.D. 0		23b. ADDRESS St. Charles, Mo	23c. DATE SIGNED Jan 7 1955
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-7-55	24c. NAME OF CEMETERY OR CREMATORY Portzig (on farm)	24d. LOCATION (City, town, or county) (State) St. Charles Co. Mo.
DATE REC'D BY LOCAL REG. Jan 13 1955	REGISTRAR'S SIGNATURE Samuel Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE Eda Keith	ADDRESS 0 Fallon Mo.

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *E. R. Keithly*

Signed.....
Student Embalmer

Licensed Embalmer No. *878*

P. O. Address *Fallon Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.