

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16918
4663

State File No. _____
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN ST. LOUIS MO	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1229 VICTOR		e. STREET ADDRESS (If rural, give location) 23 1229 VICTOR 2230	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) MARY	b. (Middle) E.	c. (Last) PORTELL	MAY	26	1955
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT 4 1876	9. AGE (In years last birthday) 78	9. AGE (In years last birthday) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) Missouri 0		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME GUS TROKEY	13b. MOTHER'S MAIDEN NAME MARY BOYER	14. NAME OF HUSBAND OR WIFE LARRY PORTELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS LUCINDA BOYER 1229 VICTOR

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) cerebral thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) old age II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 26 days
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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? 331X

22. I hereby certify that I attended the deceased from **Sept 1, 1955** to **May 25, 1955**, that I last saw the deceased alive on **May 25, 1955** and that death occurred at **4:45** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W S Rye MD	23b. ADDRESS 2752 Cherokee	23c. DATE SIGNED 5-26-55
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 28 1955	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		

DATE REC'D BY LOCAL REG. MAY 27 1955	REGISTRAR'S SIGNATURE Charles Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kates 2906 Genoa
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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.....
Signature of Student Embalmer

Signed.....

Leo J. Budde
Licensed Embalmer No. *396*
P. O. Address *St. Louis*

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.