

FILED SEP 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32342

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8146**

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MISSOURI PACIFIC HOSP.</u>		Length of stay in lb. <u>40 days 17 1/2</u>	d. STREET ADDRESS (If outside, give location) <u>3925a RUSSELL AVE.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>ARTHUR</u> Last <u>PORTER</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 19 1888</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CROSSING WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TERMINAL RAILROAD</u>	11. BIRTHPLACE (City and state or country) <u>CHETOPA KANSAS</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES W. PORTER</u>	
14. MOTHER'S MAIDEN NAME <u>ELLEN RAMSEY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>489-16-4342</u>		17. INFORMANT <u>MRS THERESA PORTER</u> Address <u>3925a RUSSELL AVE. ST. LOUIS 10.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERIPHERAL CIRCULATORY FAILURE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>SMALL BOWEL OBSTRUCTION.</u> DUE TO (c) <u>RECURRENCE OF GASTRIC CARCINOMA.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>43 DAYS</u> <u>ONE YEAR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>15ix</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY <u>Hour _____ Minute _____ Day _____ Year _____</u> <u>a.m. _____ p.m. _____</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>JULY 24 1956</u> to <u>2 SEPT. 56</u> and last saw him <u>him</u> alive on <u>2 SEPT 56</u> . Death occurred at <u>10</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Edward J. Jordan MD</u> (Degree or title)		22b. ADDRESS <u>Missouri Pacific Hosp</u>	22c. DATE SIGNED <u>3 SEPT 56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sept. 6 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Boniface</u>	23d. LOCATION (City, town, or county) (State) <u>Wimbledon North Dakota</u>
24. FUNERAL DIRECTOR <u>Weick Bros 2201 S. Grand Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 4 1956</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>

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 *J. E. Morris*

Licensed Embalmer No. *33*

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.