

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27162**

FILED AUG 2 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3024** Registrar's No. **121**

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sikeston</b>	c. LENGTH OF STAY (In this place) <b>13 Days</b>	c. CITY OR TOWN <b>Matthews</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>Route #2</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Vessie</b>	b. (Middle) <b>L.</b>	c. (Last) <b>Porter</b>	4. DATE OF DEATH (Month) <b>7</b> (Day) <b>20</b> (Year) <b>1957</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-3-1888</b>	9. AGE (In years last birthday) <b>68</b>	10. IF UNDER 1 YEAR Days <b>11</b> Hours <b>17</b>	11. IF UNDER 1 MIN. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>E. H. Porter</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Satterfield</b>	14. NAME OF HUSBAND OR WIFE <b>Elsie Ann Webb</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Dovle Porter, Matthews, Mo.</b>	ADDRESS <b></b>
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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, asthma, 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: <b>Uremia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Hypertensive Cardiovascular renal disease</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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" 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 **7-7, 1957**, to **7-20, 1957**, that I last saw the deceased alive on **7-20, 1957**, and that death occurred at **9:45 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Aldea B. Sargent M.D.</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>Sikeston, Mo.</b>	23c. DATE SIGNED <b>7-21-57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 23, 1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Garden of Memories</b>	24d. LOCATION (City, town, or county) (State) <b>Sikeston, Missouri</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>7-26-57 Mrs. Ella Hunter</b>	EMERALD DIRECTOR'S SIGNATURE <b>Edw. E. Hunter</b>	ADDRESS <b>Nunnelee Funeral Chapel, Sikeston, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

429

DATE RECEIVED

JUL 29 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 757-152

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 Philip J. Cassidy  
Licensed Embalmer No. 461

P. O. Address Sikeston, Mo.

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.