

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41148

FILED NOV 22 1957

STATE FILE NUMBER 451

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 451

1. PLACE OF DEATH a. COUNTY <b>MARION</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MARION</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HANNIBAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>HANNIBAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeths Hosp.</b>		Length of stay in lb	d. STREET-ADDRESS <b>1200 CLARK</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Porter</b> Last <b>Porter</b>			4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b>
9. AGE (In years last birthday) <b>71</b>		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) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Ralls County</b>
13. FATHER'S NAME <b>Alfred Porter</b>		14. MOTHER'S MAIDEN NAME	
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>488-24-8264A</b>	17. INFORMANT <b>FRANK PORTER</b> Address <b>HANNIBAL</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>URETHRA OBSTRUCTION</b> DUE TO (c) <b>PROSTATIC Hypertrophy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Several years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>610X</b>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 <b>8-26-56</b> to <b>11-10-57</b> and last saw him alive on <b>11-10-57</b> Death occurred at <b>4:30</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Cornelius Ewell, MD</b> (Degree or title)		22b. ADDRESS <b>Hannibal, MO</b>	22c. DATE SIGNED <b>11-12-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>Nov. 13, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Robinson Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>HANNIBAL, Missouri</b>
24. FUNERAL DIRECTOR <b>Geo. E. Roberts</b>	ADDRESS <b>1218 Bdw. Hannibal</b>	25. DATE RECD. BY LOCAL REG. <b>11-19-57</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke By W. C. Fisher</b>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must-use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

RECEIVED NOV 19 1957  
MARION CO. HEALTH DEPT.  
DATE FILED NOV 19 1957

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. ~~211~~ working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Geo E Roberts* .....

Licensed Embalmer No. 211

P. O. Address Hannibal

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.