

pt. Health,  
c., & Welfare  
S. Public  
alth Service

V. S. 300  
ev. 1-57

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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 2 1958

44731  
STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 557

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Blue Twp. (Fairmount)</b>		c. CITY OR TOWN <b>Fairmount</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>626 S. Huttig</b>		d. STREET ADDRESS <b>626 S. Huttig</b>	
Length of stay in lb <b>Life</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 Middle Last <b>MRS. LOTTIE LEE PORTER</b>			4. DATE OF DEATH Month Day Year <b>Dec. 19, 1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1887</b>
9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Indep., Mo.</b>
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Robert N. Long</b>		13b. MOTHER'S MAIDEN NAME <b>Minnie E. Mann</b>	
14. NAME OF HUSBAND OR WIFE <b>--</b>		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 <b>Mrs. Charles Shumate, Indep., Mo.</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>Probable acute myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b>			<b>?</b>
DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchitis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour a.m. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>Dec 17, 1957</b> to <b>Dec 19, 1957</b> and last saw her alive on <b>12-17-57</b> Death occurred at <b>626 S. Huttig</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul F. Bachmann</b> (Printer or title)		22b. ADDRESS <b>Indep. Mo</b>	
22c. DATE SIGNED <b>12-20-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 21, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Vt. Moriah</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>	
24. FUNERAL DIRECTOR <b>Ott &amp; Mitchell, Indep., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-21-57</b>	
26. REGISTRAR'S SIGNATURE <b>James Craig</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JAN 10 1958

DEC 29 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. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Jason White* .....  
Licensed Embalmer No. *4925* .....  
P. O. Address *On Dep 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.