Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006019
STATE FILE NUMBER

FILED FEB 20 1959 Registration District No. 150 Primary Registration District No. 4239 Registrar's No. 43

1. PLACE OF DEATH
a. COUNTY Jacksom
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lee's Summit — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 208 No. Douglas — Length of stay in 1b: 20 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson
c. CITY OR TOWN Lee's Summit — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 208 No. Douglas — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Virginia Middle: Lee Last: Porter

4. DATE OF DEATH Month: Feb. Day: 10 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: March 2 1865
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): St Louis Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Peter S. Alexander
13b. MOTHER'S MAIDEN NAME: Sarah Chimm
14. NAME OF HUSBAND OR WIFE: Charles F. Porter (dec)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Alpha Trundle Address: Lee's Summit Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO~~ (b) Cerebral Hemorrhage — 12 da
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4222
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 4-26-52, to 2-10-59 and last saw ~~him~~ her alive on 2-9-59
Death occurred at Lee's Summit Mo 1:50 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: M Knight (Degree or title) MD
22b. ADDRESS: Lee's Summit Mo
22c. DATE SIGNED: 2-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/13/1959
23c. NAME OF CEMETERY OR CREMATORY: Lee's Summit
23d. LOCATION (City, town, or county) (State): Lee's Summit Mo.

24. FUNERAL DIRECTOR: Langsford Funeral Home ADDRESS: Lee's Summit Mo.
25. DATE RECD. BY LOCAL REG.: 2/11/59
26. REGISTRAR'S SIGNATURE: W Langsford

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 7 1959

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.