RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-031700
STATE FILE NUMBER

FILED VS SEP 28 1959 53 Registration District No. Primary Registration District No. 3010 Registrar's No. 341

IDED

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Cape Girardeau — Length of stay in 1b: 2 Wks
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Southeast Hospital — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: New Madrid
c. CITY OR TOWN: Rt#1 New Madrid — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Edmonia — Middle: — Last: Porter
4. DATE OF DEATH: Month: Sept. Day: 23 Year: 1959
5. SEX: F
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: March 16, 1904
9. AGE (last birthday): ~~58~~ 55 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Unknown
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Albert Hamilton
13b. MOTHER'S MAIDEN NAME: Alice Taylor
14. NAME OF HUSBAND OR WIFE: Aaron Porter
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: Aaron Porter — Address: New Madrid, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Small Bowel Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Ventral Incisional Hernia — 35 years
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Marked Obesity
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 9-14-59, to 9-23-59 and last saw her alive on 9-23-59
Death occurred at 7:10 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. Cheshaw [illegible]
22b. ADDRESS: Cape Girardeau, Mo
22c. DATE SIGNED: 9-25-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Sept 27 1959
23c. NAME OF CEMETERY OR CREMATORY: Sand Hill
23d. LOCATION (City, town, or county) (State): New Madrid Mo

24. FUNERAL DIRECTOR: Ponder Funeral Home — ADDRESS: Lilbourn Mo.
25. DATE RECD. BY LOCAL REG.: 9-26-59
26. REGISTRAR'S SIGNATURE: Irene Kasten

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 5030

P. O. Address _____

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