

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042370

FILED VS DEC 11 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **211083**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>50 days</b>	c. CITY OR TOWN <b>St. Louis</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. Louis Chr. Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4228a McPherson</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Emma</b> Last <b>Porteous</b>	4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>59</b>
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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>11/9/1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Norris City, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
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13a. FATHER'S NAME <b>Marshall E. Garrett</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Ellen Greer</b>	14. NAME OF HUSBAND OR WIFE <b>William M. Porteous Sr.</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>487-20-0951</b>	17. INFORMANT <b>John A. Garrett, Norris City, Ill.</b>	Address
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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>Left Middle Cerebral Artery Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>11 days.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arteriosclerosis</b> <b>50 days.</b>
	DUE TO (c) <b>Generalized Arteriosclerosis 332x</b> <b>50 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease occurred given in PART I (a) <b>Terminal Rt. Bronchopneumonia - 5 days.</b>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year
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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 <b>St. Louis, Mo.</b>	COUNTY	STATE
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21. I attended the deceased from <b>Oct. 8, 1959</b> to <b>Nov. 27, 1959</b> and last saw her/him alive on <b>Nov. 27, 1959</b> Death occurred at <b>2:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>	22b. ADDRESS <b>5800 Arsenal</b>	22c. DATE SIGNED <b>11/28/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-30-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 30 1959</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Home

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11/13/30

John A. Garrett, Florida City, Fla.

John A. Garrett, Florida City, Fla.

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Merwin L. Kempe

Licensed Embalmer No. 4052  
P. O. Address St. Louis

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.