

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011177

FILED VS. MAR 28 1960

149

Primary Registration District No. 1002 Registrar's No.

1472

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>20 YRS</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1700 Prospect</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Booker</u> Middle <u>B.</u> Last <u>Porter</u>			4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>60</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/1893</u>
9. AGE (last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PACKING HOUSE</u>	11. BIRTHPLACE (City and state or country) <u>Paris, Texas U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Samuel Porter</u>	13b. MOTHER'S MAIDEN NAME <u>Maudie Wallace</u>
14. NAME OF HUSBAND OR WIFE <u>Mary Porter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	16. SOCIAL SECURITY NO. <u>500-096599</u>
17. INFORMANT <u>Louise Porter</u>		Address <u>1902 E 31st</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)	
20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____	Month, Day, Year _____		
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 <u>Feb 16, 1960</u> to <u>Mar 3, 1960</u> and last saw him alive on <u>Mar 3, 1960</u> Death occurred at <u>2:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. L. Stuper</u> (Degree or title)		22b. ADDRESS <u>2400 Perry City</u>	22c. DATE SIGNED <u>3/3/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3-12-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KANSAS CITY SCHOOL OUT (OP) PARK</u>	23d. LOCATION (City, town, or county) (State) <u>RED WAGON MO</u>
24. FUNERAL DIRECTOR <u>C. K. TERFORD FUNERAL HOME K.C., MO</u>		25. DATE RECD. BY LOCAL REG. <u>3-11-60</u>	26. REGISTRAR'S SIGNATURE <u>Mona Minshall</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Dwy BT

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 *Kenneth G. Goy*

Licensed Embalmer No. 4431

P. O. Address *2000*

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