

FILED VS OCT 14 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

60-033270
STATE FILE NUMBER

Registration District No. 27 Primary Registration District No. 5077 Registrar's No. 112

300
1-57

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|--|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Bates</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Bates</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Amoret</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Amoret</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pine Tree Rest Home</u> | | Length of stay in lb <u>1 yr.</u> | d. STREET ADDRESS (If outside, give location) <u>2 miles N. E.</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Ellora</u> Last <u>Porter</u> | | | 4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1960</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-20-1874</u> | 9. AGE (In years last birthday) <u>86</u> | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>homemaker</u> | 11. BIRTHPLACE (City and state or country) <u>Bellaire, Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>Fletcher Keller</u> | | 13b. MOTHER'S MAIDEN NAME <u>Matilda White</u> | | 14. NAME OF HUSBAND OR WIFE <u>Joseph H. Porter, dec.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT <u>James Porter, Amoret, Missouri</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>Cerebral hemorrhage</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Recurrent "Strokes" before</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
| 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.) <u>4221</u> | | |
| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u> | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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>8-25-1960</u> , to <u>9-7-1960</u> and last saw <u>her</u> alive on <u>8-31-1960</u> Death occurred at <u>9-2-60 11:55A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (In full name) <u>Carter W. Kuter M.D.</u> | | | 22b. ADDRESS <u>Butler, Mo.</u> | | 22c. DATE SIGNED <u>9-12-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>9-5-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mulberry Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Homer Township, Bates Co. Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Archer & Mangold, Amsterdam, Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Sept. 21-60</u> | 26. REGISTRAR'S SIGNATURE <u>Kendall Krey</u> | |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Robert L. Mangold*

Licensed Embalmer No.....4972.....

P. O. Address...LaCygne, Kana.

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.