URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 14 1960 53 Registration District No. 3010 Primary Registration District No. 441 Registrar's No. 60-037709 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY: CAPE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: CAPE GIRARDEAU — Length of stay in 1b: 16 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: SOUTHEAST MISSOURI HOSP. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: SCOTT
c. CITY OR TOWN: CHAFFEE — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 114 GRAY AVE. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: CARRIE Middle: IONA Last: PORTER
4. DATE OF DEATH: Month: NOV. Day: 5 Year: 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: FEB. 18, 1894
9. AGE (last birthday): 66 — IF UNDER 1 YEAR: Months 8 Days 17 — 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: —
11. BIRTHPLACE (City and state or country): COBDEN, ILLINOIS
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William SANDERS
13b. MOTHER'S MAIDEN NAME: MARTHA FOX
14. NAME OF HUSBAND OR WIFE: JOE (NMN) PORTER (Dec'd.)
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. WOODROW JOHNSON — Address: FERGUSON, 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): Aortic Regurgitation — 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):
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. ☐ 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 1957, to 11-5-60 and last saw her alive on 11-4-60
Death occurred at 355 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Harold D. Ridings (Degree or title) MD
22b. ADDRESS: Cape Girardeau, Mo
22c. DATE SIGNED: 11-7-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Nov. 7, 1960
23c. NAME OF CEMETERY OR CREMATORY: UNION PARK CEMETERY
23d. LOCATION (City, town, or county) (State): CHAFFEE, MISSOURI
24. FUNERAL DIRECTOR: BISPLINGHOFF FUNERAL HOME — ADDRESS: CHAFFEE, MO
25. DATE RECD. BY LOCAL REG.: 11-10-60
26. REGISTRAR'S SIGNATURE: Irene Kaster

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

NOV 15 1960

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, N

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