

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 30 1960

-60-045501

STATE FILE NUMBER

Registration District No. 25 Primary Registration District No. 5300 Registrar's No. 133

IDED

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osborn R.F.D.</u>		Length of stay in 1b <u>11 Yr.</u>		c. CITY OR TOWN <u>Osborn</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>Osborn R.F.D. No 1</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Osborn R.F.D. NO. 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Marilyn</u> Middle <u>Ruth</u> Last <u>Porter</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>60</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 10 1949</u>	9. AGE (last birthday) <u>11 Yr.</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>	IF UNDER 24 HR Hours <u>11</u> Min. <u>11</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (City and state or country) <u>Cameron Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Ben S. Porter</u>			13b. MOTHER'S MAIDEN NAME <u>Allene Hunt Porter</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, <u>None</u> or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ben S. Porter Osborn 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>Fibrosarcoma primary</u> DUE TO (b) <u>in the liver</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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>July 20, 1960</u> to <u>Dec 22-1960</u> and last saw her alive on <u>Dec 16, 1960</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>Cameron Mo</u>			22c. DATE SIGNED <u>12-23-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>			23d. LOCATION (City, town, or county) <u>Osborn Mo</u>		(State)	
24. MEDICAL DIRECTOR <u>Poland Funeral Home</u>		ADDRESS <u>Cameron Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-24-60</u>		26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Laurence J. Thompson

Licensed Embalmer No. 473

P. O. Address Cameron

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