

PURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-020555
STATE FILE NUMBER

AMENDED

Registration District No. **43** Primary Registration District No. **3007** Registrar's No. **171**

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CARTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 37 DAYS	c. CITY OR TOWN GRANDIN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NONE
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First JAMES Middle ALLEN Last PORTERFIELD			4. DATE OF DEATH Month JUNE Day 8 Year 1961	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-20-72	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) OCOONTO, WISCONSIN	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME JOHN PORTERFIELD	13b. MOTHER'S MAIDEN NAME FANNIE CRAWFORD	14. NAME OF HUSBAND OR WIFE NONE
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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) YES	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.
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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) PNEUMONIA.		INTERVAL BETWEEN ONSET AND DEATH 3 Weeks
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) GENERAL DEBILITY.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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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 Month, Day, Year	Hour a.m. p.m.
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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	COUNTY	STATE
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21. I attended the deceased from **May 2, 1961** to **June 8, 1961** and last saw her **alive on** **6:15 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Medical Svc., VA Hospital, Poplar Bluff, Mo.	22b. ADDRESS	22c. DATE SIGNED 6/13/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 10, 1961	23c. NAME OF CEMETERY OR CREMATORY Brookside Cemetery	23d. LOCATION (City, town, or county) (State) Ocoonto, Wisconsin
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24. FUNERAL DIRECTOR Edwards Funeral Home Doniphan, Mo.	25. DATE RECD. BY LOCAL REG. 6/19/1961	26. REGISTRAR'S SIGNATURE Thelma Graham
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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 by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P.O. Address _____

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.