

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-018793

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 30

FILED MAY 28 1962

VS 300
Rev. 4/59

0440
20440

3

4 0

5 1

6

7 1

8 2

9 151X

10

11

12 90-2

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOUND City</u>		Length of stay in 1b <u>48 yrs</u>	c. CITY OR TOWN <u>MOUND City</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>MOUND City</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT EDGAR PORTER</u>		4. DATE OF DEATH Month Day Year <u>MAY 24, 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>10-8-1885</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 4 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Light & Power</u>	11. BIRTHPLACE (City and state or country) <u>MOUNT PLEASANT TEX.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>ROBERT J. PORTER</u>	
13b. MOTHER'S MAIDEN NAME <u>NANCY L. HALL</u>		14. NAME OF HUSBAND OR WIFE <u>MELVINA A. PORTER</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. _____	17. INFORMANT Address <u>WILBUR PORTER MOUND City, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Metastatic Cancer of Stomach</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>24 hours</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 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 a.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>October 1960</u> to <u>May 24-62</u> and last saw him alive on <u>May 24/62</u> Death occurred at <u>12.30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James M. Rae MD</u> (Degree or title)		22b. ADDRESS <u>Mound City Mo</u>	22c. DATE SIGNED <u>5/25/62</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5/26/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>	23d. LOCATION (City, town, or county) <u>MOUND City Mo.</u>
24. FUNERAL DIRECTOR <u>James H. Crawford</u> ADDRESS <u>MOUND City, Mo.</u>		25. DATE REC'D BY LOCAL REG. <u>5/25/1962</u>	26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>

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 *James H. Crawford*
Licensed Embalmer No. 4796

P. O. Address Mount City, Mo.

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.