

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042377

Registration District No. 137 Primary Registration District No. _____ Registrar's No. 275 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 26 1962

VS 300
Rev. 4/59

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1291-3
131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>app. 1 1/2 miles S.E. Mt Zion</u> Length of stay in lb <u>app. 2 yrs</u>		c. CITY OR TOWN <u>Deepwater</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>app. 1 1/2 miles S.E. Mt Zion</u>		d. STREET ADDRESS (If outside, give location) <u>R7D # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>CLYDE RAY PORTER</u>			4. DATE OF DEATH Month Day Year <u>Nov 14 1962</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>12-15-1907</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>29</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labourer</u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
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13a. FATHER'S NAME <u>W.M. Porter</u>		13b. MOTHER'S MAIDEN NAME <u>Mattie Proctor</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Chas. Watha Fort Scott Kans.</u>	
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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:			INTERVAL BETWEEN ONSET AND DEATH <u>Death at once</u>
IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>			
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) <u>None</u>		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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>Self inflicted 22 caliber wound of head</u>	
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20c. TIME OF INJURY Hour <u>7</u> s.m. <u>pm</u> Month, Day, Year <u>11-14-62</u>	
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>In home</u>		20f. CITY, TOWN, OR LOCATION <u>Deepwater, R#2; Henry Mo.</u>		COUNTY STATE	
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21. I attended the deceased from Unattended to Unattended and last saw her/him alive on _____
 Death occurred at appx 7 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>S. B. Hughes, M.D. Acting from Henry Co., Mo.</u>		22b. ADDRESS <u>Clinton, Mo.</u>		22c. DATE SIGNED <u>11/19/62</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Scott Kans.</u>		23d. LOCATION (City, town, or county) (State) <u>Fort Scott Kans.</u>	
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24. FUNERAL DIRECTOR ADDRESS <u>CHENEYS FUNERAL HOME FORT SCOTT KANS.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 15 1962</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>	
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USE BLACK INK OR TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

10-1-1917

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 F. L. Scheibey

Licensed Embalmer No. 4513

P. O. Address Clinton 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.

Received General 11-13-52 W.B. J.P.