No. 300
10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED MAY 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16064

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 165

1. PLACE OF DEATH
a. COUNTY: Calloway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fulton
c. LENGTH OF STAY (in this place): 11yrs +
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospt No 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Marion
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Palmyra County Home
d. STREET ADDRESS (If rural, give location): Marion Co 0641

3. NAME OF DECEASED (Type or Print): a. (First) VIOLET b. (Middle) c. (Last) PORTER
4. DATE OF DEATH (Month) (Day) (Year): May 15 1950
5. SEX: F
6. COLOR OR RACE: negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: DK Aprox
9. AGE (In years last birthday): 82-?
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY? america
13a. FATHER'S NAME: DK
13b. MOTHER'S MAIDEN NAME: DK
14. NAME OF HUSBAND OR WIFE:
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'S SIGNATURE OR NAME: Records State Hospital No 1 Fulton Mo ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. senility — 4 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-1, 1950, *to* 5-15, 1950, *that I last saw the deceased alive on* 5-15, 1950 *and that death occurred at* 6 *m., from the causes and on the date stated above.*

23a. SIGNATURE: R R Price (Degree or title) MD
23b. ADDRESS: Fulton Mo
23c. DATE SIGNED: 5-15-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: May 19, 1950
24c. NAME OF CEMETERY OR CREMATORY: anatomical Board
24d. LOCATION (City, town, or county) (State): St. Louis Mo

DATE REC'D BY LOCAL REG.: May 20-1950
REGISTRAR'S SIGNATURE: Marietta Lawrence 426
25. FUNERAL DIRECTOR'S SIGNATURE: Maugin Funeral Home, Fulton, Mo ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAY 22 1950
District Health Officer No. 9,
District File Number.....

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Walter J. Haines, Jr.

Signed.....
Student Embalmer

Licensed Embalmer No. 4557

P. O. Address Fulton, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.