

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **554**

FILED FEB 14 1952

BIRTH NO. _____ REG. DIST. NO. **59** PRIMARY REG. DIST. NO. **4097** Registrar's No. **19**

1916

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

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass	
b. CITY OR TOWN Harrisonville	c. LENGTH OF STAY (in this place) 6 days	c. CITY OR TOWN Harrisonville, Rural-Clinton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 0190 07 Miles South Harrisonville	

3. NAME OF DECEASED (Type or Print)	a. (First) NED	b. (Middle) WALLACE	c. (Last) PORTER	4. DATE OF DEATH (Month) (Day) (Year) February 3 - 1952
-------------------------------------	-----------------------	----------------------------	-------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH December 19 - 1896	9. AGE (In years last birthday) 55	<input type="checkbox"/> UNDER 1 YEAR	<input type="checkbox"/> UNDER 1 MONTH	<input type="checkbox"/> UNDER 1 HOUR	<input type="checkbox"/> UNDER 1 MIN.
--------------------	-------------------------------	---	--	---	---------------------------------------	--	---------------------------------------	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)	10b. KIND OF BUSINESS OR INDUSTRY Filling Station Operator	11. BIRTHPLACE (State or foreign country) Syracuse, Morgan Co, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME Ned Wallace Porter	13b. MOTHER'S MAIDEN NAME Anna Fisher	14. NAME OF HUSBAND OR WIFE Ada Porter
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Mrs Carl Miller	ADDRESS 519 S. Oakland K.C. Mo.
---	-----------------------------------	--	--

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity, Severe		

19a. DATE OF OPERATION <input checked="" type="checkbox"/>	19b. MAJOR FINDINGS OF OPERATION 443X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <input checked="" type="checkbox"/>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>
---	--	--

22. I hereby certify that I attended the deceased from **Feb 4, 1950**, to **Feb 3, 1952**, that I last saw the deceased alive on **Feb 3, 1951**, and that death occurred at **11 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE O. B. Bargen MD	(Degree or title)	23b. ADDRESS Harrisonville Mo	23c. DATE SIGNED Feb. 5 1952
---------------------------------------	-------------------	--------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE February 6 - 52	24c. NAME OF CEMETERY OR CREMATORY La Monte Cemetery	24d. LOCATION (City, town, or county) (State) La Monte Mo
---	----------------------------------	---	--

DATE REC'D BY LOCAL REG. Feb 5 - 1952	REGISTRAR'S SIGNATURE Lora Barnard	457	25. FUNERAL DIRECTOR'S SIGNATURE Atkinson Brothers	ADDRESS Archie, Mo
--	---	-----	---	---------------------------

RECEIVED
FEB 9 1952
CASS COUNTY
HEALTH DEPARTMENT

AUG 16 1954

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

Wendell Harrison

Licensed Embalmer No. 3920

P. O. Address *Harrisonville*

Signed.....

Student Embalmer

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

SMC