

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14668

State File No. ....

FILED APR 25 1952

318

1003

Registrar's No. .... 3256

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. .... 3256			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>40-yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		0			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1115 McCausland Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>1115 McCausland Ave.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Josephine</u> b. (Middle) <u>A.</u> c. (Last) <u>Porter</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 6, 1952</u>						
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W. 2</u>	8. DATE OF BIRTH <u>Oct. 7, 1854</u>		9. AGE (In years last birthday) <u>97</u>	IF UNDER 1 YEAR <u>5</u> Months	IF UNDER 1 YEAR <u>29</u> Days	IF UNDER 1 YEAR <u>0</u> Hours	IF UNDER 1 YEAR <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Unk. Cline</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Charles F. 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. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Minnie Porter, 1115 McCausland Ave.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Upper respiratory Infection</u> ANTECEDENT CAUSES DUE TO (b) <u>Advanced age - Inanition</u> DUE TO (c) <u>Senile Anemia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis several years.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>  <u>omnip.</u>  <u>several years.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>H75X.</u>					
22. I hereby certify that I attended the deceased from <u>2-19</u> , 19 <u>51</u> , to <u>3-14</u> , 19 <u>52</u> ; that I last saw the deceased alive on <u>3-20</u> , 19 <u>52</u> ; and that death occurred at <u>1:30P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>M. G. Wood</u>				(Degree or title)		23b. ADDRESS <u>109 McCausland</u>		23c. DATE SIGNED <u>4-7-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 9, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>APR 7 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur J. Donnelly</u> <u>0 Lindell Blvd.</u>				

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

**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 .....  
Student Embalmer

Signed W. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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.