

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2964
0684

State File No.

FILED FEB 7 - 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. CITY OR TOWN	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		STREET ADDRESS (If rural, give location)	
BARNES HOSPITAL 0		Box 60 A Route 1 0120/	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	NMN	Porter		Jan. 21, 1955
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) Months Days
Male 2	Colored	Widowed 2	8-4-1896	58 5 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
Labour			Pocahontas, Mississippi/	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Unknown	Unknown	Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS
Yes WW 1	?	Essie Mae Brison Box 60 A, Route 1 Robinsonville, Missouri

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epidermoid carcinoma of the floor of the mouth with metastases		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 143X

22. I hereby certify that I attended the deceased from Dec. 17, 1954, to Jan. 21, 1955, that I last saw the deceased alive on Jan. 21, 1955, and that death occurred at 3:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. P. Kamiller, M.D.	BARNES HOSPITAL	1/21/55

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	1-24-55		Jackson, Mississippi

DATE REC'D BY LOCAL REG. JAN 24 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....
Fulton E. Calk

Licensed Embalmer No. *419*

P.O. Address *St Paul*

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.