

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16858

FILED JUN 3 1957

STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. 4221 Registrar's No. 37

Health, Welfare, Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOUND CITY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MOUND CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NONE</u>				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PORTER</u> ^{First} <u>JERRY</u> ^{Initial} <u>PORTER</u> ^{Last}				4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1957</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-1896</u>		9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>STATE HWY. DEPT</u>		11. BIRTHPLACE (City and state or country) <u>ATCHISON CO. MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>P. J. COMBS</u>				14. MOTHER'S MAIDEN NAME <u>RACHAEL DE FREESE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW1</u>			16. SOCIAL SECURITY NO. <u>500-34-4763</u>		17. INFORMANT <u>Virginia C Combs</u> <u>Mound City</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAR LINOMA RT. Lung & METASTASIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</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>163X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>July 1, 1956</u> to <u>May 25, 1957</u> and last saw <u>him</u> alive on <u>May 25, 1957</u> Death occurred at <u>9:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Waac J. Surang M.D.</u>				22b. ADDRESS <u>Alcapon, Mo</u>			22c. DATE SIGNED <u>5-25-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5-27-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ENGLISH GROVE</u>			23d. LOCATION (City, town, or county) (State) <u>FAIRFAX MO</u>			
24. FUNERAL DIRECTOR <u>Bartholomew Mirtuney, Rock Pt. Mo</u>				25. DATE READ BY LOCAL REG. <u>5/28/57</u>		26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>			

(Licensed Embalmer's Statement on Reverse Side)

469-0

JUN 5 1957
JUN 10 1957
JUN 13 1957

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 *Gratz B. Bartholomew*

Licensed Embalmer No. *317*

P. O. Address *Rose P.O.*

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.