

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015270

STATE FILE NUMBER

FILED APR 23 1958

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. 65

5. 300  
1-57

82

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>PIKE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>PIKE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LOUISIANA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>CLARKSVILLE</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>PIKE CO HOSP.</b>		Length of stay in 1b <b>2 Mo.</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARCHIE TAYLOR PORTER.</b>			4. DATE OF DEATH Month Day Year <b>APRIL 11 1958</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-1892</b>
9. AGE (In years last birthday) <b>76</b>		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) <b>CUSTODIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CEMETERY</b>	11. BIRTHPLACE (City and state or country) <b>FLEMINGBURG KY</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>RALPH PORTER</b>	
13b. MOTHER'S MAIDEN NAME <b>BETTY JANE ARNSTRONG</b>		14. NAME OF HUSBAND OR WIFE <b>ORAJ PORTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>35670-0449</b>	
17. INFORMANT Address <b>ORAJ PORTER, CLARKSVILLE, MO</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>coronary occlusion</b> DUE TO (c) <b>generalized arteriosclerosis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>	
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 <b>15 Jan. 58</b> to <b>11 April 58</b> and last saw him alive on <b>10 April 58</b> Death occurred at <b>7:45 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John H. Hoover, M.D.</b>		22b. ADDRESS <b>Clarksville, Mo.</b>	
22c. DATE SIGNED <b>17 April 58</b>		23a. BURIAL, CREATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>APR. 13-1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN WOOD CEM</b>	
23d. LOCATION (City, town, or county) (State) <b>CLARKSVILLE MO</b>		24. FUNERAL DIRECTOR ADDRESS <b>CARROLL COLLIET CLARKSVILLE, April 18, 1958</b>	
25. DATE RECD. BY LOCAL REG. <b>MO</b>		26. REGISTRAR'S SIGNATURE <b>Berniece Collier</b>	

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 *Geo. M. Collier* .....

Licensed Embalmer No. *3839* .....  
P. O. Address *Louisiana* .....

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.