

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030858

State File No. ....

FILED SEP 8 1958

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 8327

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 3 mo.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 26 St. Louis Chronic Hosp. 22A			
3. NAME OF DECEASED (Type or Print) a. (First) Minerva		b. (Middle) Porch	
c. (Last) Porch		4. DATE OF DEATH (Month) (Day) (Year) 8-21-58	
5. SEX female	6. COLOR OR RACE col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 7-3-73
9. AGE (in years last birthday) 85		10. 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) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Claiborne Watson		13b. MOTHER'S MAIDEN NAME Mary Watson	
14. NAME OF HUSBAND OR WIFE Ben. Porch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME St. Louis Chronic Hospital Records		ADDRESS 5800 Arsenal	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Basilar Congestion of Heart</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> <u>3 1/2 mo.</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> <u>3 1/2 mo.</u> 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 420.0	
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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-6-58</u> , 19 <u>  </u> , to <u>8-21-58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>8-21-58</u> , 19 <u>  </u> , and that death occurred at <u>2:29 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>John W. Beckham M.D.</u>		23b. ADDRESS 5800 Arsenal St.	
23c. DATE SIGNED 8/22/58			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 8/29/61	
24c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEMETERY		24d. LOCATION (City, town, or county) (State) WELLSFON MD.	
DATE REC'D BY LOCAL REG. AUG 28 '58		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas J. Gates</u>		ADDRESS 4107 Finney	

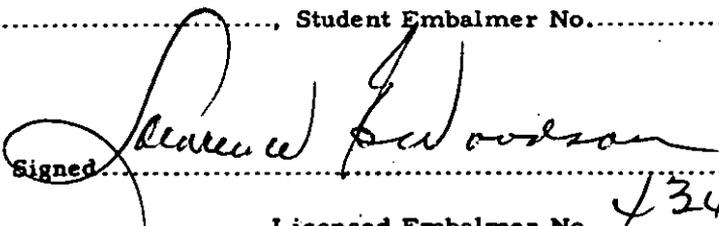
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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  .....

Licensed Embalmer No. 434

P. O. Address 4107 St

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.