

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032058

STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 69

S. 300
1-57

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 <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kearney</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</u>		Length of stay in lb <u>13 Dvs</u>	d. STREET ADDRESS <u>RR#1</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Reginald</u> Middle <u>Earl</u> Last <u>Porter</u>			4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>58</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>August 11, 1881</u>		9. AGE (In years last birthday) <u>77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Lathrop, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John W. Porter</u>		13b. MOTHER'S MAIDEN NAME <u>Madron Pope</u>		14. NAME OF HUSBAND OR WIFE <u>Mayme L. Gow</u>	
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 Address <u>Mrs. Mayme Porter, Kearney, Missouri</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>Hypostatic Pneumonia -</u> <u>admission of slow</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arterial hemorrhage - Aug 11, 1958 -</u> DUE TO (c) <u>arterial hemorrhage - Aug 11, 1958 -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>May 1958</u> <u>Aug. 1958</u>
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. Month, Day, Year _____					
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>May 1958</u> to <u>Aug 27, 1958</u> and last saw him alive on <u>Aug 27, 1958</u> Death occurred at <u>Excelsior Springs</u> on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE <u>J.R. M. Erickson MD</u> (Degree or title)			22b. ADDRESS <u>Excelsior Springs Mo</u>		22c. DATE SIGNED <u>8-28-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-28-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kearney, Missouri</u>
24. FUNERAL DIRECTOR <u>Fry Funeral Home, Kearney, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9/15/58</u>		26. REGISTRAR'S SIGNATURE <u>Barolise Hutchings</u>



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

Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address *Chillicothe, Mo.*

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.