

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039783

STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 144 Primary Registration District No. 4234 Registrar's No. 122

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>Iron</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ironton, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Farmington</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>St. Marys</u>		Length of stay in 1b <u>3 weeks</u>	d. STREET ADDRESS <u>418 W. College</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>C</u> Last <u>Porter</u>			4. DATE OF DEATH Month <u>II</u> Day <u>17</u> Year <u>58</u>		
5. SEX <u>Female</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>12/28/1886</u>		9. AGE (In years last birthday) <u>71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Crystal City, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>J.A. Lawrence</u>			14. MOTHER'S MAIDEN NAME <u>Elza Johnson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>492-24-6051a</u>	17. INFORMANT <u>Harry Porter</u> Address <u>Des Moines Iowa</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>Terminal bilateral bronchial pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of Pancreas (inoperable)</u>					<u>?</u>
DUE TO (c) <u>Metastasis to liver, Obstructive jaundice</u>					<u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>157 X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 <u>          </u> Month, Day, Year a. m. <u>          </u> p. m. <u>          </u>					
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	
				<u>11-17-58</u>	
21. I attended the deceased from <u>10-26-58</u> to <u>11-17-58</u> and last saw her <sup>her</sup> alive on <u>11-17-58</u> Death occurred at <u>4:55 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. E. Jarland, M.D.</u> (Degree or title)			22b. ADDRESS <u>Ironton, Missouri</u>		22c. DATE SIGNED <u>II/19/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>II/19/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Farmington Mo</u>	
24. FUNERAL DIRECTOR <u>Cozean Funeral Home</u> ADDRESS <u>Farmington</u>			25. DATE RECD. BY LOCAL REG. <u>II/19/58</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Avis Jones</u>

(Licensed Embalmer's Statement on Reverse Side)

DEC 2 1958

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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 *C. P. Howell*.....

Licensed Embalmer No. *36*.....

P. O. Address *W. Va.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.