RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-012193
STATE FILE NUMBER

FILED VS APR 11 1960

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 50

DED

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY: Ray			a. STATE: Missouri	b. COUNTY: Lafayette
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Richmond	Length of stay in 1b: 8 Days		c. CITY OR TOWN: Corder	Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Ray County Hospital	Inside Limits: Yes ☐ No ☒		d. STREET ADDRESS (If outside, give location): 301 Wall St.	Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Clara	B.	Porter		April	3	1960

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HR Hours / Min.
Female	White	Married ☒	April 27, 1869	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Housewife Retired	Home	Lafayette Co. Mo	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
James H. McGuire	Zarilda Farrel	John B. Porter

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
No	No	John B. Porter	Corder, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Congestive Circulatory failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebral thrombosis c̄ Encephalomalacia 1 wk

DUE TO (c) Arterio sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 March 29, 1960, to April 3, 1960 and last saw her alive on April 3, 1960

Death occurred at 11:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Edwin Wilson, D.O.	1815 Main, Higginsville, Mo.	4/4/60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
Burial	4/5/60	Mount Zion	Johnson County	Mo

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
E. S. James	Concordia, Mo	4-5-1960	Mabel Jackson

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT — MEDICAL CERTIFICATION — BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by me, Student Embalmer No.

working under my personal supervision.

Student ______________________ Signed E. S. James
Signature of Student Embalmer

Licensed Embalmer No. 2058

P. O. Address Concordi

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