SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED MAR 28 1961

-61-011395

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2402

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 40 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4764 Leduc
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Sam (SAMUEL) Middle: Last: Porter

4. DATE OF DEATH: Month 3 Day 10 Year 61

5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4-27-1889
9. AGE (last birthday): 71
IF UNDER 1 YEAR: Months 10 Days 13
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Mfg
11. BIRTHPLACE (City and state or country): Cochran Ga
12. CITIZEN OF WHAT COUNTRY: U S A

13a. FATHER'S NAME: Samuel Porter Sr
13b. MOTHER'S MAIDEN NAME: Unk
14. NAME OF HUSBAND OR WIFE: Ina Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

17. INFORMANT: Ina Porter
Address: 4764 Leduc

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable Subacute Bacterial Endocarditis with Embolism to the Brain
INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 430.0

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

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 3-3-61, to 3-10-61 and last saw him alive on 3-10-61

Death occurred at 4:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Sydney A. Green, M. D.
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 3-10-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-14-1961
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county): St. Louis Co (State): Mo

24. FUNERAL DIRECTOR: JAS H. RANDLE & SON ADDRESS: 3133 Bell Ave
25. DATE RECD. BY LOCAL REG.: MAR 13 1961
26. REGISTRAR'S SIGNATURE: Neal Smith M.D.

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Washin

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.