

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7614

STATE FILE NUMBER

FILED AUG 23 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE			b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>			Length of stay in 1b			c. CITY OR TOWN <u>St. Louis</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DePaul Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			d. STREET ADDRESS (If outside, give location) <u>4211 Enright Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>Mozella</u> Middle <u>Porter</u> Last <u>Porter</u>			4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>61</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>Unk</u>	9. AGE (last birthday) <u>Abt. 60</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Shreveport, La.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Henry Ford</u>			13b. MOTHER'S MAIDEN NAME <u>Mattie Senclair</u>			14. NAME OF HUSBAND OR WIFE <u>Theodore Porter</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Theodore Porter 4211 Enright</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>Chronic Lymphocytic leukemia.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>don't know</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						<u>2040</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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>8-9-61</u> to <u>8-13-61</u> and last saw her alive on <u>8-13-61</u> Death occurred at <u>9:30 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Walter H. Spooner</u> (title) <u>M.D.</u>						22b. ADDRESS <u>1515 St. Louis</u>		22c. DATE SIGNED <u>8-15-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bu rial</u>		23b. DATE <u>8-18-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>A. L. Beal Und. 4303 Delmar</u>				25. DATE RECD. BY LOCAL REG. <u>AUG 16 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Arthur P. Heilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Eastern

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.