

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033251

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 377 Primary Registration District No. 590 Registrar's No. 2240

VS 300  
Rev. 4/59

14042

2 21 2

3

4 1

5 0

6

7 0

8 2

9309X

10

11

1286-0

13

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>VALLEY PARK</u>		Length of stay in 1b <u>4 Mo</u>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VALLEY PK. NURS. HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4917 WESTMINSTER</u>
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>MAE</u> Last <u>PORTER</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>1</u> Year <u>62</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSE</u>	9. AGE (last birthday) <u>65</u>
11. BIRTHPLACE (City and state or country) <u>SPRINGFIELD, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>ANDREW S. PORTER</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>—</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>	
17. INFORMANT <u>VALLEY PK. NURS. HOME</u>		Address <u>VALLEY PK. MO.</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 Brain Syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH <u>37 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetic Mellitus</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>Feb. 1, 1962</u> to <u>Aug. 1, 1962</u> and last saw her alive on <u>July 29, 1962</u> . Death occurred at <u>9:40 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert Anderson M.D.</u>		(Degree or title)	22b. ADDRESS <u>1562 Clark Ave</u>
22c. DATE SIGNED <u>8-2-62</u>			
23a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>	23b. DATE <u>8-4-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD MO.</u>
24. FUNERAL DIRECTOR <u>RAINEY</u>		ADDRESS <u>SPRINGFIELD MO</u>	25. DATE RECD. BY LOCAL REG. <u>8-2-62</u>
		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

AUG 18 5 17 SA

**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 *Frank Proloff*

Licensed Embalmer No. 4356

P. O. Address St. Louis 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.