

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009216

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2717** STATE FILE NUMBER

FILED MAR 14 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4108 Westminster
3. NAME OF DECEASED (Type or print) First CLARENCE Middle A. Last PORTELL			4. DATE OF DEATH Month MARCH Day 6 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/20/1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 62
11a. FATHER'S NAME John Portell		11b. MOTHER'S MAIDEN NAME Rose Pratt	12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME John Portell		13b. MOTHER'S MAIDEN NAME Rose Pratt	
14. NAME OF HUSBAND OR WIFE Elsie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. INFORMANT May Bicket, 2730 Chippewa Ave.			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EPIDERMOID CARCINOMA OF LARYNX WITH METASTASES DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH Months 161x
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 10/19/62 to 3/6/63 and last saw her/him alive on 3/6/63 Death occurred at 4:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title) M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/6/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-11-63	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. MAR 8 1963	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1

2 **21 9**

3 **2**

4 **0**

5 **3**

6

7 **0**

8 **1**

9

10

11

12 **52-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

52

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 W. W. Wilkinson

Licensed Embalmer No. 3575

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.