

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-031166

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 279

**FILED AUG 26 1963**

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kirksville</b>		Length of stay in lb <b>years</b>	c. CITY OR TOWN <b>Kirksville</b>
c. FULL NAME OF (If NOT in hospital, give location) <b>Kirksville Osteopathic</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>516 East Hickory</b>
3. NAME OF DECEASED (Type or print) <b>MABLE LAURA PORTER</b>		4. DATE OF DEATH <b>August 14 1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE STATUS <del>XXXXXX</del> Never Married <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/8/89</b>
9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>	11. BIRTHPLACE (City and state or country) <b>Little York, Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>U S</b>		13a. FATHER'S NAME <b>William Porter</b>	
13b. MOTHER'S MAIDEN NAME <b>Laura McIntire</b>		14. NAME OF HUSBAND OR WIFE <b>never married</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No No</b>		16. SOCIAL SECURITY NO. <b>[redacted]</b>	
17. INFORMANT <b>Cary Porter, Kirksville, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Anoxemia</b>			<b>1 hour</b>
DUE TO (c) <b>Overwhelming Toxicity due to Perforated Gall Bladder</b>			<b>3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Peritonitis</b>			PART III. Deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 Month, Day, Year a.m. p.m.			
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 <b>8-13-63</b> to <b>8-14-63</b> and last saw <b>alive</b> on <b>8-14-63</b> Death occurred at <b>11:10 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James F. Lipe D.O.</b>		22b. ADDRESS <b>800 W. Jefferson, Kirksville Mo</b>	22c. DATE SIGNED <b>8-16-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/17/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville, Adair, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Foster Memorial Home, Kirksville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Aug. 16. 1963</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Raloff</b>

*No permit issued*

*JAMES F. GIPE, D.O.*

**AUG 27 1963**

**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 *Nova E. Foster*

Licensed Embalmer No. *4742*  
P. O. Address *Fukani, 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.