

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
Kearney 25456
File No. _____
Registered No. *69* St. _____ Ward _____

1. PLACE OF DEATH
County *Phelps* Registration District No. *677*
Township _____ Primary Registration District No. *4403*
City *Raela* (No. _____) St. _____ Ward _____

2. FULL NAME *James S Porter*
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 3, 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 1 24

8. OCCUPATION OF DECEASED *Stock buyer*
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

15. DATE OF DEATH (MONTH, DAY AND YEAR) *July 27 1928*

I HEREBY CERTIFY, That I attended deceased from _____, 19____ to *July 27*, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Result of a fight - being struck on head by a foreign body

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *George Porter*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Crevecoeur*

12. MAIDEN NAME OF MOTHER *OK*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *OK*

14. INFORMANT (Address) *James Porter Raela Mo*

15. FILED *July 12, 1929* *Joe F. Myers* REGISTRAR

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) *Robert H. Conner* M.D.
, 19____ (Address) *Raela Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Raela Cemetery* DATE OF BURIAL *7/29 1928*

20. UNDERTAKER *H. H. Newland* ADDRESS *Raela*

1928
81
4
2
33
1
2
31

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

