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REC'D JUN 17 1938MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH18669  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Lafayette Registration District No. 460  
 (b) Township Devis Primary Registration District No. 427A Registered No. 23  
 (c) City Higginsville (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James M Porter

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Mrs. Sarah Jane Porter

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 21 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 14

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Pettis Co 0  
 (STATE OR COUNTRY) Mo.

FATHER 13. NAME John B Porter  
 14. BIRTHPLACE (CITY OR TOWN) Dent  
 (STATE OR COUNTRY) Ky.

MOTHER 15. MAIDEN NAME Francis Meddox  
 16. BIRTHPLACE (CITY OR TOWN) Dent  
 (STATE OR COUNTRY) Ky.

17. INFORMANT Mrs Roy Blake  
 (ADDRESS) Higginsville Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Payne Cemetery DATE May 7 1938

19. FUNERAL DIRECTOR Hubert & Minnerhagen  
 (ADDRESS) Higginsville Mo

20. FILED May-10-38 Tiffany Walsh  
 Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 5, 1938

22. HEREBY CERTIFY, That I attended deceased from Mich 2, 1935, to May 4, 1938

I last saw him alive on 4th May, 1938. Death is said to have occurred on the date stated above, at 10:30am at home.  
 The principal cause of death and related causes of importance were as follows:

Cause of death nephritis  
Edema

Date of onset

not  
known

Other contributory causes of importance:

Name of operation no operation Date of \_\_\_\_\_What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_

(Signed) L. B. Coogins, D.O. M. D.(Address) Higginsville, Mo.

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No. .... or by ....., Registered Apprentice No. ....

working under my personal supervision.

Signed .....

Licensed Embalmer No. ....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

18669  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Lafayette Registration District No. 460  
 (b) Township Higginsville Primary Registration District No. 4274 Registered No. 23  
 (c) City Higginsville (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James M. Porter  
 (a) Residence, No. \_\_\_\_\_ St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED and  
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
79 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19.

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED McK 2 1938

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 5 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Cause of death, Septicemia and Edema  
130  
 Other contributory causes of importance:  
Cause auto intoxication

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify L. B. Cozzano M.D.  
 (Address) Higginsville Mo.

SUPPLEMENT

REG. FEE: FEE SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important. Cause of death to be properly classified. Plain terms, in plain terms, in plain terms.

Local Registrar.

