

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

34974
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson, Registration District No. 299
 (b) Township Kaw, Primary Registration District No. 1002
 (c) City Kansas City, Mo. (d) Street No. 815 Norton, 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 636 Faye Ola Barry Porter,
 (a) Residence, No. 815 Norton, 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 Female 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 John X. Porter,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 14, 1904,

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 6 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home,
 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) Missouri, 0

FATHER 13. NAME J. S. Barry, 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana, 0

MOTHER 15. MAIDEN NAME Kitty C. Sloan,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri,

17. INFORMANT (ADDRESS) John X. Porter,
815 Norton, Kansas City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn Cemetery DATE 10/14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stine & McClure,
3235 Gillham Plaza, K. C., Mo.

20. FILED 10-13-39 M. M. M. M. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 12, 19 39

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him alive on about 1 month ago, 19____. Death is said to have occurred on the date stated above, at 2:55 am

The principal cause of death and related causes of importance were as follows:

Heart, the Corvix Uteri
45
 Date of onset 7 yrs.

Other contributory causes of importance:

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 _____
 (Signed) Ther. M. Helwig M. D.
 (Address) 116 Prof. Bldg.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

50 Mo-12-2-35 I X14022

Dr. Helwig,
Professional Bldg.
2:00-3:00

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed *[Signature]*

Licensed Embalmer No. 1415

P. O. Address R. C. M.

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 this body is not embalmed, above space should be left blank.