

FILED NOV 19 1942

Registration District No. **149**

Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson,**

(b) City or town **Kansas City,**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Trinity Lutheran Hospital, 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **90 days,**
(Specify whether)

In this community **Since 1917**
years, months or days)

3. (a) PRINT FULL NAME **Joseph F. Porter,**

3. (b) If veteran, name war **No.**

3. (c) Social Security No. **No.**

4. Sex **Male 0**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. Jennie R. Henderson Porter**

6. (c) Age of husband or wife if alive **79** years

7. Birth date of deceased **January 27 1863**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	9	10	hr. min.

9. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **X**

MOTHER FATHER { 12. Name **Francis J. Porter,**

13. Birthplace **New York,**
(City, town, or county) (State or foreign country)

14. Maiden name **Louis Francis**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Jennie R. H. Porter,**

(b) Address **825 West 56th St., Kansas City, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-9-42**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (c) **11-8-42** (Date received local registrar) (b) **M. M. Brown** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson,** **46**

(c) City or town **Kansas City,**
(If outside city or town limits, write "RURAL")

(d) Street No. **825 West 56th Street,**
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)

If yes, name country **X** **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **7th**
year **1942** hour **7:55** minute **A.** M.

21. I hereby certify that I attended the deceased from **Oct-15**, 19**41**, to **Nov-7**, 19**42**
that I last saw him alive on **Nov 6**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death:
Coronary thrombosis 6 mo
Chr. infect. at. hep. 2 yrs
Ben. arteriosclerosis 3 yrs

Due to **131B**

Other conditions (including pregnancy within 6 months of death):
Chr. Hepatitis
Prostatic Hypertrophy

Major findings:
Of operations:

Of autopsy **Coronary thrombosis**
Myocardial infarction

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of Injury _____

23. Signature **Paul H. Frost** (M. D. or other) **11/7/42**
Address **106 W 14th St. Kansas City, Mo.** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. Carl Brust

111
111
111
111

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 4158

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Joseph P. Porter
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive, years.....

7. Birth date of deceased. June 27, 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 10 If less than one day, hr..... min.....

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (c) Place: burial or cremation.....
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director..... (b) Address.....

19. (a) 7/2/42 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month..... day..... year..... hour..... minute..... M.
21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy.....

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
..... (Specify type of place)
While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-36370