

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 689

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:
4139 Pennsylvania Avenue /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. --- (Specify whether
 In this community 43 Years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4139 Pennsylvania Avenue
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country ---

3. (a) PRINT FULL NAME Mrs. Mary Frances Porter
 3. (b) If veteran, name war No 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month February day 8th
 year 1943 hour 6 minute 30 A. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife Mr. John E. Porter
 6. (c) Age of husband or wife if alive --- years
 7. Birth date of deceased August 10 1862
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1943 to Feb 8, 1943 that I last saw him alive on Feb 8, 1943 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>5</u>	<u>28</u>	hr. <u>---</u> min. <u>---</u>

Immediate cause of death Chronic myocarditis
arteriosclerosis
 Due to arteriosclerosis

9. Birthplace Boston Massachusetts
 (City, town, or county) (State or foreign country)
 10. Usual occupation At Home

Due to Senility
 Other conditions (Include pregnancy within 3 months of death)
 Major findings of operations ---
 Of autopsy ---

11. Industry or business ---
 12. Name Thomas Hagerty
 13. Birthplace Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Lyons
 15. Birthplace Ireland
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Mathe Dunn
 (b) Address Domona Missouri
 17. (a) Burial (b) Date thereof Feb. 10, 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery
 18. (a) Signature of funeral director D. H. Newcomer
 (b) Address 1401 Brush Creek Blvd.
 19. (a) 2-9-43 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

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 W. B. Casbatt (M. D. or other)
W. B. Casbatt Date signed Feb-9-43

361

Porter

Original Body
7/15

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.....

C Hervey Quisenberry

Licensed Embalmer No. *4070*

P. O. Address *RC 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 this body is not embalmed, fact should be so stated above.