

SEP 9 1943 66
Registration District No. _____

Primary Registration District No. 6244

State File No. _____
Registrar's No. 435

1. PLACE OF DEATH: Washington

(a) County: Washington

(b) City or town: rural of Union W.P.
(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 _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME: James Edward Portell

3. (b) If veteran, name war: _____

3. (c) Social Security No. _____

4. Sex: M

5. Color or race: W

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

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: June 6 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 4 If less than one day _____ hr. _____ min.

9. Birthplace: Washington Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation: none

11. Industry or business: _____

MOTHER FATHER

12. Name: Oswa Portell

13. Birthplace: Washington Mo. D
(City, town, or county) (State or foreign country)

14. Maiden name: Margaret L. Portell

15. Birthplace: Washington Mo. D
(City, town, or county) (State or foreign country)

16. (a) Informant: Oswa Portell

(b) Address: Cadet, Mo. R-1.

17. (a) Burial (b) Date thereof: 6 11 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Old Mount Mo.

18. (a) Signature of funeral director: Max Willmer

(b) Address: Cadet Mo. R-1.

19. (a) 8-12-1943 (b) Joseph L. Plummer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Washington

(c) City or town: rural
(If outside city or town limits, write "RURAL")

(d) Street No.: near Cadet
(If rural, give location)

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

If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1943 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from June 7 1943 to June 10 1943
that I last saw him alive on June 9 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Intra cranial hemorrhage 3da

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature: J. P. Ingelson (M. D. or other) _____

Address: 895 1/2 St. P. Date signed: 6-10-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 4
District File Number 943-2670
Date Filed 9-8-43

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.