

FILED MAY 11 1944

Primary Registration District No. **4812**

Registrar's No. **41**

1. PLACE OF DEATH:

(a) County **Julliman**
(b) City or town **Newtown**
(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 **9 months** years, months or days)

3. (a) PRINT FULL NAME

RACHEAL PORTER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** / 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **Feb 2 1861**
(Month) (Day) (Year)

8. AGE: Years **83** Months **2** Days **8** If less than one day hr. min.

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

10. Usual occupation **Home wife**

11. Industry or business _____

12. Name **George Sanford**

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

14. Maiden name **Martha**

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

16. (a) Informant **Mrs. J. C. Dickson**

(b) Address **Newtown Mo**

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation **Emerson Res.**

18. (a) Signature of funeral director **Judd & Payne**

(b) Address **Newtown Mo**

19. (a) **Apr. 21, 1944** (b) **Mrs. John Zedd**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County **105**
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **10th**
year **1944** hour **8** minute **A** M.

21. I hereby certify that I attended the deceased from **Feb 1** 19**45** to **Apr 10** 19**44**
that I last saw her alive on **Apr 10** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure**

Due to **Chronic Myocarditis**

Due to _____

Other conditions **93d**
(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 **G. A. Dale** (M. D. or other) **20**
Address **Newtown, Mo** Date signed **4/11/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1553

(Licensed Embalmer's Statement on Reverse Side)

DEC 1 1952

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.....

T. Howard Gield

Licensed Embalmer No.

3240

P. O. Address.....

New York

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15995
Registrar's No. 41

Registration District No. 348 Primary Registration District No. 4512

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Newtown
(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 Racheal Porter

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased Feb
(Month) (Day) (Year)

8. AGE: Years 93 Months _____ Days _____ In less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 21/44 (b) Mrs. John Todd
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan Co.

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

15995