

S. No. 2  
M-5-43  
7-5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3579  
State File No. \_\_\_\_\_  
Registrar's No. 3

FILED JAN 30 1947  
Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Lemay  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Miller Nursing Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town Lemay, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Meramec Bottom Rd.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Porta  
3. (b) If veteran, name war no 3. (c) Social Security No. NO  
4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife SATHERINE  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased September 27, 1862  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 4th,  
year 1947 hour 5 minute P M.  
21. I hereby certify that I attended the deceased from 10/27/46, 19\_\_\_\_, to Jan. 4th, 1947.  
that I last saw him alive on Jan. 1st, 1947,  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
84 3 18 hr. min.

Immediate cause of death Acute Myocarditis Duration 3 days

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation farmer  
11. Industry or business retired

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Chronic Nephritis 3 months  
(Include pregnancy within 3 months of death)  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
12. Name Peter Porta  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Bohr  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

Major findings: Of operations no  
Of autopsy no

16. (a) Informant John Porta, Jr.  
(b) Address Mattese, Mo.  
17. (a) burial (b) Date thereof 1-7-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mattese, Mo.

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? \_\_\_\_\_

18. (a) Signature of funeral director Fendler Und. Co.  
(b) Address 7420 Michigan Ave.  
19. (a) 1-7-47 (b) Ruth J. Salento  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place) Means of injury 0  
23. Signature Dr. W. H. Walters (M. D. no)  
Address 3608 S. Grand Blvd. Date signed 1/6/47

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

Dr. Walters  
3608 S. Grand

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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.....

*Oliver E. Lander*

Licensed Embalmer No.....

*4148*

P. O. Address.....

*H. Lander*

**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.