

No. 2
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5-17-39
X 47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14037

FILED MAY 2 1947

Registration District No. 7

Primary Registration District No. 5-65-C

Registrar's No. 14

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence
(c) City or town Ash Grove R.R.
(If outside city or town limits, write "RURAL")
(d) Street No. Brook Top
(If rural, give location)
(e) Citizen of foreign country? Russia (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lillie May Porter

3. (b) If veteran, name war L 3. (c) Social Security No. None

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

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

7. Birth date of deceased 10 - 30 - 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 5 22 hr. min.

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

10. Usual occupation None

11. Industry or business _____

12. Name J. W. Porter

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

14. Maiden name Fanny Ann Chatham

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

16. (a) Informant Oren Porter

(b) Address Ash Grove R.R. #

17. (a) Buried (b) Date thereof 4-23-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Halltown

18. (a) Signature of funeral director Magnum

(b) Address Box 110

19. (a) 4-24-47 (b) W. S. Bessley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21
year 1947 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from March 21
1947 to April 21, 1947
that I last saw her alive on April 21, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal flu Duration 2 weeks

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? _____ (Specify type of place)
Means of injury _____

23. Signature S. M. Clark M.D. (M. D. or other) _____

Address Halltown, Mo. Date signed 4-22-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 447-506

Date Filed APR 29 1947

MAY 8 1947

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 J. R. Seiman

Licensed Embalmer No. 3297

P. O. Address Millen 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.