

FILED OCT 8 1947

State File No. _____
Registrar's No. 255

Registration District No. 58 Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Noyes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)

In this community 3 Months
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM CLARENCE PORTER

3. (b) If veteran, name war. None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased. 7 - 25 - 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

85	2	2	hr. min.
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9. Birthplace. Bridgeport Connecticut
(City, town, or county) (State or foreign country)

10. Usual occupation. Retired

11. Industry or business _____

MOTHER FATHER

12. Name. Clarence Porter

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

14. Maiden name. Emily Mills

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

16. (a) Informant Mrs. Elsie M. Wolf

(b) Address 1309 Wilson Ave., Columbia, Mo.

17. (a) Removal (b) Date thereof. 9-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Bridgeport, Conn.

18. (a) Signature of funeral director Parsons Funeral Service
Columbia, Mo.

(b) Address _____

19. (a) 9-27-47 (b) Mrs R E Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. 1309 Wilson Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1947 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 26 - 1947 to Sept 27 1947
that I last saw him alive on Sept 27
and that death occurred on the date and hour stated above.

Immediate cause of death. Uremia Duration 2 days

Due to degenerative changes ?

Due to Hypertrophy of Prostate ?

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

Major findings: 131B

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? 0

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Frank E Decker M. D. or other Dr
Address Columbia Mo Date signed 9-27-47

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

Date Filed 10/27/47

District File Number

District Health Officer No. 9,

RECEIVED

OCT 9 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 Charles Waring

Licensed Embalmer No. 4132

P. O. Address Columbia, 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.