

S. No. 300
M-10-47
y. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 128835
Registrar's No. 1493

FILED APR 17 1948
Registration District No. 1948/9

Primary Registration District No. 1002

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

388

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
315 E 43 rd St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
In this community 20 Yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 315 E. 43 rd St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Ellen H. Porter
(b) If veteran, name war No
(c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 3
year 1948 hour 1 minute 00 A.M.
21. I hereby certify that I attended the deceased from July 25, 1944, to _____, 1947.
that I last saw her alive on 4/19, 1947,
and that death occurred on the date and hour stated above.

4. Sex F. 5. Color or race W
6. (a) Single, widowed, married, divorced Widow
(b) Name of husband or wife Chas. U. Porter
(c) Age of husband or wife if alive No years
7. Birth date of deceased Dec. 6 1876
(Month) (Day) (Year)

Immediate cause of death Spilepsy
Duration 25 yrs

8. AGE: Years Months Days If less than one day
71 3 27 hr. min. 0

Due to RT Temporal chronic adhesive arachnoiditis
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)
Major findings: 8/5

10. Usual occupation Home

11. Industry or business No

12. Name Geo. M. Harrison

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

14. Maiden name Katherine Bowers

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

16. (a) Informant Mrs. Chas. Gaiser

(b) Address 315 E 43 rd St

17. (a) Cremation (b) Date thereof 4 5 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELMWOOD

18. (a) Signature of funeral director: Stine & McClure

(b) Address Kansas City, Mo.

19. (a) 4-5-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

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 _____ (e) Means of injury _____

23. Signature W. H. Woodson M.D. (M. D. or other)

Address Kansas City Mo Date signed 4/13/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

Dr. W. H. Garrison
Prop. Bishop

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..... *Robert Id Reed*

Licensed Embalmer No. *3745*

P. O. Address..... *H. C. 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.