WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

N. G. Balsley

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Jasper

Township ~~Marian Galena~~ or Village or City Joplin (NO. 2024 Byers St. Ward)

Registration District No. 411 File No. 35462

Primary Registration District No. 2002 Registered No. 4579

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Franklin Dorsey Porter

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH July (Month) 19 (Day), 1849 (Year)

AGE 68 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Ohio

PARENTS

NAME OF FATHER Don't Know

BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't Know

MAIDEN NAME OF MOTHER Don't Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE mo.

(Informant) Joplin

(ADDRESS) Wallace Porter

Filed Oct 3 1917 Joplin J. A. Chenoweth REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct (Month) 2 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July 15, 1917, to Oct 1, 1917, that I last saw him alive on Sept 28, 1917, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

93 Organic Heart Disease

95B ~~Cardiac Dropsy~~

(Duration) yrs. mos. ds.

Contributory (SECONDARY) 79

(Duration) yrs. mos. ds.

(Signed) M G Balsley M. D.

Oct 2 1917 (Address) Joplin Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Park Cemetery | DATE OF BURIAL Oct 3, 1917

UNDERTAKER Jopt Knells Md Co | ADDRESS Carthage Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), *191*..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS