

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

36929³

1. PLACE OF DEATH

County James Registration District No. 860 File No. 295
Township Claver Primary Registration District No. 6130 Registered No. _____
City Hollister (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Resided - No. James S. Porter _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 16 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____hra. or _____min.
37 6 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ex U.S. Capt.
(b) General nature of industry, business, or establishment in which employed (or employer) M. Eng.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) N. Y. City
(STATE OR COUNTRY) N. Y.

PARENTS

10. NAME OF FATHER Benjamin J. Porter
11. BIRTHPLACE OF FATHER (CITY OR TOWN) N. Y. City
(STATE OR COUNTRY) N. Y.
12. MAIDEN NAME OF MOTHER Mary E. Porter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New Bedford
(STATE OR COUNTRY) Mass.

14. INFORMANT E. A. Blair
(Address) St Louis Mo.

15. FILED 12/16 1924 R. B. Ketchum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 1924

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1924, to Dec 16, 1924, that I last saw him alive on Dec 16, 1924, and that death occurred, on the date stated above, at 12:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia causing Nephritis
12/16/24
(duration) yrs. _____ mos. _____ ds. _____

CONTRIBUTORY (SECONDARY) _____
(duration) yrs. _____ mos. _____ ds. _____

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: France

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Harry J. Evans M. D.
, 19 _____ (Address) Hollister Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodland Cemetery N.Y. DATE OF BURIAL 12/19 1924

20. UNDERTAKER R. W. Wheeler ADDRESS Branson Mo

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Fireman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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

1. PLACE OF DEATH

County Laney Registration District No. 860 File No. 295
 Township Oliver Primary Registration District No. 6130 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Sidney Porter
 (a) Residence, No. 6145 1/2 Ill. St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 4 yrs. 4 mos. 16 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mollie M. Porter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 30 - 1887

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>36</u>		<u>11</u>	<u>16</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Ex U.S. Capt.
 (b) General nature of industry, business, or establishment in which employed (or employer) M. Eng
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER Benjamin Curtis Porter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER May Louise Clark

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bridgport Conn. (STATE OR COUNTRY) _____

14. INFORMANT C. A. Blair (Address) 2616 - N. 73 St.

15. FILED 12/16 24 1924 St. Louis, Mo. R. A. Thornhill

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 1924

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1924, to Dec 16, 1924 that I last saw him alive on Dec 16, 1924, and that death occurred, on the date stated above, at 12:30 P. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
High Blood Pressure Causing Apoplexy

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED France
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No.
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Harry T. Evans, M. D.
 , 19 (Address) Hallister, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn Cemetery, N.Y. DATE OF BURIAL 12/19 1924

20. UNDERTAKER R. O. Wheelchel ADDRESS Beaconsfield, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

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"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,* of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus,* etc.), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

52736
1919-3

COPIPLEMENTAL

Dr. James Stewart

Dear Sir

Will you kindly send me
certified copy of ~~Birth~~ ^{Death} Certificate
of James S. Porter, died at
Hallister, Mo. Dec 16-1924.

Being unforseen on this

Taney Co

