

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

Do not use this space.

1. PLACE OF DEATH U.S.V.B.H. #67,

County Jackson
Township Kaw
City Kansas City, Mo. (No. U. S. Veterans Hosp)

Registration District No. 399
Primary Registration District No. 1002

File No. 21335
Registered No. 2570 (Ward)

2. FULL NAME PORTER, William Thomas

Spanish-American War.

(a) Residence, No. Braddyville, Iowa. St. _____ Ward. _____
(Usual place of abode)

Sgt. Co. E. 4th Mo. Inf
(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male

White

Married

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

Myrtle A. Porter.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14, 1874

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

53

2

19

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jacksonville,
(STATE OR COUNTRY) Illinois.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Hospital Records.

(Address) K 6. 22nd

15. July 5 27 M. M. Grove
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3, 1927.

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to July 3, 1927
that I last saw h. in alive on July 3, 1927, and that death occurred, on the date stated above, at 7:00 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

V. H. D. Mitral Stenosis, and mitral Regurgitation, with marked cardiac hypertrophy and decompensation.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Unknown

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination & X-Ray

(Signed) E. J. ROSE, Medical Off. in Charge.
S.E.W., 19 U.S.V.B. H. #67, K.C. 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Braddyville Iowa

DATE OF BURIAL

7/5 1927

20. UNDERTAKER

Westford Undertaker

ADDRESS

City

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.

