

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

Do not use this space.  
*L. F. H. 6152*

**1. PLACE OF DEATH**  
 County *Greene* Registration District No. *318* File No. ....  
 Township ..... Primary Registration District No. *2001* Registered No. *158*  
 City *Springfield* No. *Springfield Hospital* St. *153* Ward) .....

**2. FULL NAME** *Clara H. Porter*  
 (a) Residence No. *SR 7 D # 1* *Shaffard* *mo*  
 (Usual place of abode) (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** *Female* **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** *O. B. Porter*

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** *May 19-1900*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>28</i>	<i>9</i>	<i>9</i>	

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work *Housewife*  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** *Ind*

**10. NAME OF FATHER** *Jacob Larentz*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** *Germany*

**12. MAIDEN NAME OF MOTHER** *Lena Smith*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** *Ind*

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *Feb 28 1929*

**17. I HEREBY CERTIFY** That I attended deceased from *Feb 27* 19*29* to *Feb 28* 19*29* that I last saw h. *alive* on *Feb 28* 19*29* and that death occurred, on the date stated above, at *12/40, m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
*Gril Peritonitis*  
*117B*  
*129/111B1* (duration) yrs. mos. *2* da.

**CONTRIBUTORY** *Perforating Duod - Ulcer* (SECONDARY) (duration) yrs. mos. *4* da.

**18. WHERE WAS DISEASE CONTRACTED** *Shaffard Ind*  
 IF NOT AT PLACE OF DEATH, DATE OF *Feb 27*

**1 DID AN OPERATION PRECEDE DEATH.** *yes* DATE OF *Feb 27*

**WAS THERE AN AUTOPSY?** .....

**WHAT TEST CONFIRMS DIAGNOSIS**  
 (Signed) *Arthur Smith*, M. D.  
 , 19 (Address)

\*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.

**14. INFORMANT** *O. B. Porter* **19. PLACE OF BURIAL, CREMATION, OR REMOVAL** *Seymour Mo* **DATE OF BURIAL** *3/1 1929*  
 (Address) *Shaffard Mo*  
**15. FILE** *3-1 29* *O. C. Ford* **20. UNDERTAKER** *Lena Schmees* **ADDRESS** *Springfield*  
 REGISTRAR

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.

MAR 22 1929

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WRITE PLAINLY, WITH UNFADING INK—RECORD

