

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.

MAY 26 1930

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

Do not use this space.

9255

1. PLACE OF DEATH

County Johnson  
Township Jackson  
City Jackson

Registration District No. 435  
Primary Registration District No. 5322

File No. \_\_\_\_\_  
Registered No. 7  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

John Farmer Porter  
(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Georgia E. Porter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 15-1840

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
89 11 20

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER James B. Porter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Katharine Capps

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

14. INFORMANT L. B. Porter  
(Address) Kingsville Mo

15. FILED 4/17, 1930 L. J. Timbrow  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 3, 1930, that I last saw him alive on March 2, 1930, and that death occurred, on the date stated above, at 3:15 P.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Hypostatic Pneumonia  
185  
1110  
(duration) \_\_\_\_\_ yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Heavy Fall (duration) \_\_\_\_\_ yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED 185  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. Druggill, M. D.  
, 19 \_\_\_\_\_ (Address) Kingsville Mo.

\*State the DISEASE CAUSING DEATH, or 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 Rock Spring Cemetery DATE OF BURIAL Mar 5 1930

20. UNDERTAKER W. H. Grodman ADDRESS Holden Mo

31  
2

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KORADUAG

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County Johnson Registration District No. 435 File No. 9255  
 Township Jackson Primary Registration District No. 5592 Registered No. 7  
 City..... (No)..... St. .... Ward)

2. FULL NAME John Farmer Porter  
 (a) Residence. No. .... 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. mos. 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 M  
 (write the word)

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, hrs. or min.

**8. OCCUPATION OF DECEASED**

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

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

(c) Name of employer .....

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**14.**

INFORMANT  
(Address)

**15.**

FILED 3/4 1930

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 3 1930

17. I HEREBY CERTIFY, That I attended deceased from .....

that I last saw h..... alone on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hypostatic pneumonia

CONTRIBUTORY Heart fall in Barn  
(SECONDARY) yard.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., 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.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

19

**20. UNDERTAKER**

**ADDRESS**

PERMANENT RECORD

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

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

SUPPLEMENTARY

55-44