

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

Do not use this space.

16196

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City, Mo (No. 601 West v34th Street)

Registration District No. 399
Primary Registration District No. 1007

File No. 2104
Registered No. 2104
St. _____ Ward _____

2. FULL NAME Mrs. Harriet Almedia Porter

(a) Residence. No. 601 West 34th St. 5 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 6, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66 0 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Adam Cauble

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

12. MAIDEN NAME OF MOTHER Sarah King

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

14. INFORMANT J. H. Porter
(Address) 601 W 34th Street

15. FILED 5/16, 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1930

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 14, 1930, that I last saw her alive on May 14, 1930, and that death occurred, on the date stated above, at 17:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

460
Carcinoma of Transverse
Colon (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) none
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF about May 1-30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) E. A. Burkhardt, M. D.

5/16, 1930 (Address) 3346 Summit - 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 Forest Hill Cemetery DATE OF BURIAL 5/17/30¹⁹

20. UNDERTAKER Freeman Mortuary, 104 W 42nd ADDRESS Kc 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.

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

