

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

Do not use this space.

33345

1. PLACE OF DEATH

County Jackson Registration District No. 421
Township Madison Primary Registration District No. 4249
City Peters (No. _____) St. _____ (Ward _____)

2. FULL NAME

William Wayne 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 <u>male</u> | 4. COLOR OR RACE <u>white</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) | |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF | | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 3 - 1930</u> | | | |
| 7. AGE | YEARS <u>5</u> | MONTHS <u>22</u> | DAYS <u>22</u> |
| | If LESS than 1 day, _____ hrs. or _____ min. | | |
| 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Child</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer. | | | |

9. BIRTHPLACE (CITY OR TOWN) Peters
(STATE OR COUNTRY) Mo

| | |
|---------|---|
| PARENTS | 10. NAME OF FATHER <u>Robert Porter</u> |
| | 11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Jackson Co</u> (STATE OR COUNTRY) <u>Mo</u> |
| | 12. MAIDEN NAME OF MOTHER <u>Ella Burgee</u> |
| | 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Perry Co</u> (STATE OR COUNTRY) <u>Mo</u> |

14. INFORMANT Mrs Robert Porter
(Address) Peters Mo

15. FILED 10/24/30 J.E. Rutledge
1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 25 1930
17. I HEREBY CERTIFY, That I attended deceased from October 21, 1930, to October 24, 1930 that I last saw him alive on October 24, 1930 and that death occurred, on the date stated above, at 1:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
1274
(duration) _____ yrs. _____ mos. 4 ds.

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? physical examination
(Signed) L.E. Brasley, D.O. M.D.
Oct. 25, 1930 (Address) 204 Main St. Peters, 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 Methodist Chantry DATE OF BURIAL Oct 26 1930

20. UNDERTAKER Trink and Co ADDRESS Peters Mo

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

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.

