

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

Do not use this space.

3316

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

St. Louis (No. City Hosp # 2)

File No.....

Registered No.....

1096

St.....

Ward.....

2. FULL NAME

(a) Residence No.....
(Usual place of abode)

*John Porter
2656a Morgan St., 21 Ward.*

(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

male

4. COLOR OR RACE

col.

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

married

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

Katie

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

10.23-1883

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

48

3

5

8. OCCUPATION OF DECEASED

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

Teamster

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

104

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ala. 2

10. NAME OF FATHER

John Porter

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala

14.

INFORMANT.....

(Address)

*Katie Porter
2299a Chestnut*

15.

FILED.....

1932

Wm E. Stanley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan. 28 1932

17. *No Physician Attendance*
HEREBY CERTIFY, That I attended deceased from.....

19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... *420 a.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Abscess of Brain (Traumatic)
Risks by Mule St. Louis Mo.
Accident*

CONTRIBUTORY (SECONDARY)

(duration) *10* yrs. mos. ds.

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).....

J. W. Kerner, M.D.

(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

Green wood

Feb. 2 1932

20. UNDERTAKER

Joe Hughes

ADDRESS

2620 Stanton

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.

11