

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4769

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town M.C.  
 (c) Name of hospital or institution: 45th + Hardesty 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution one month  
 (Specify whether years, months or days)

8. (a) PRINT FULL NAME Porter T. Stover 356  
 8. (b) If veteran, name war unknown  
 8. (c) Social Security No. unknown

4. Sex m 5. Color or race w  
 6. (a) Single, widowed, married, divorced widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased unknown  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
approx 50 X X hr. min.

9. Birthplace unknown (City, town, or county) (State or foreign country)  
 10. Usual occupation Railroad worker  
 11. Industry or business \_\_\_\_\_  
 12. Name unknown  
 13. Birthplace unknown (City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace unknown (City, town or county) (State or foreign country)

16. (a) Informant's own signature James Gleason  
 (b) Address Dept. Coroner  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-39 (Month) (Day) (Year)  
 (c) Place: burial or cremation Willow Springs Mo  
 18. (a) Signature of funeral director H. T. Ferguson  
 (b) Address 24 E. 1st  
 19. (a) Dec. 16, 1939 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson  
 (c) City or town Willow Springs  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 50 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-15 Year 1939 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from 140 P. to \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Traumatic shock  
 Due to Fracture of mandible  
 Due to Fracture of acetabulum (rt)  
 Other conditions: Injury by fall  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Do not know  
 (b) Date of occurrence 12-15-39  
 (c) Where did injury occur? K.C. Mo (City or town) (County) (State)  
 (d) Did injury occur in, or about home, on farm, industrial place, in public place?  
fell from pulley (Specify type of place) (e) Means of injury \_\_\_\_\_  
 While at work \_\_\_\_\_  
 23. Signature Victor J. Miller (M. D. or other) \_\_\_\_\_  
 Address K.C. Mo Date signed \_\_\_\_\_

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Francis Walton*

Registered Apprentice No. *2744*

working under my personal supervision.

*Francis Walton*

Signed *By G. E. Ferguson*

Licensed Embalmer No. *2744*

P. O. Address *G. E. Ferguson*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.