

FILED MAR 19 1940

Registration District No. 8

Primary Registration District No. 4359

Registrar's No. _____

62

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Parma
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution? Death at Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community most of life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town New Parma "Rural"
(If outside city or town limits write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Bessie Porter 136
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25th
year 1940 hour 7 minute 50 P.M.
21. I hereby certify that I attended the deceased from Feb 18, 1940
to Feb 25, 1940
that I last saw him alive on Feb 25, 1940
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife W. E. Porter 6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased Nov. 18 - 1900 (1000)
(Month) (Day) (Year)

Immediate cause of death Lobar pneumonia

8. AGE: Years 37 Months 3 Days 7 If less than one day hr. _____ min. _____

Due to Influenza IV

9. Birthplace Ill
(City, town, or county) (State or foreign country)

Other conditions 5 months pregnant
(Include pregnancy within 3 months of death)

10. Usual occupation House wife

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name J. L. Place
13. Birthplace Kan.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann
15. Birthplace Ill
(City, town, or county) (State or foreign country)

16. (a) Informant Husband + Mother
(b) Address Parma

17. (a) Burial (b) Date thereof Feb 27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden Cemetery

18. (a) Signature of funeral director Lander + Son
(b) Address Complete Mo

19. (a) 2-26-40 (b) D. C. ...
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
or _____ (e) Means of injury _____

23. Signature D. C. ... (M. D. or other) _____
Address Parma, Mo Date signed 2/26/40

RECEIVED

District Health Officer No. 2,

District File Number 340-813

Date Filed 3/14/40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 75187

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County New Madrid
 (b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Pessie Porter

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>27</u>	<u>2</u>	<u>2-</u>	_____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5/19/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(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. ? _____ years.

20. DATE OF DEATH Month Feb. Day 25 - Year 40
 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I saw him alive _____ and that death occurred on the date and hour stated above.
 Immediate cause of death Lobar Pneum.

Influenza -

Due to _____
 Due to 5 mo. pregnancy

Other conditions _____
(Include pregnancy within 3 months of death)

Major operations: no labor at abortion
 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) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (b) Means of injury

23. Signature [Signature] (M. D. or other) _____
 Address [Address] Date signed _____

SUPPLEMENTARY

