

JAN 9 1942

Registrar's No. **2691**

Registration District No. _____

Primary Registration District No. **20D**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Koch**
(c) Name of hospital or institution: **Robert Koch Hospital 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **3 months 9 days**
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **DCM**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **9**
(d) Street No. **2509a Glasgow** (If rural, give location) **1**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Mary Lee Porter

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widow 7**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **1 31 1900**
(Month) (Day) (Year)

8. AGE: Years **41** Months **11** Days **0** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Stamstress**

11. Industry or business _____

MOTHER FATHER { 12. Name **Will Porter 9**
13. Birthplace **UNKNOWN 9**
(City, town, or county) (State or foreign country)
14. Maiden name **Alice Long 9**
15. Birthplace **UNKNOWN 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Koch Hospital Records**
(b) Address **Koch Mo.**

17. (a) **BURIAL** (b) Date thereof **1-5-42**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **Bernie Love**
(b) Address **Washington**

19. (a) **JAN 5 1942** (Date received local registrar) **L. M. Carroll** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **31**
year **1941** hour **7** minute **20 A.** M.

21. I hereby certify that I attended the deceased from **22** 19 **41** to **12-31** 19 **41**
that I last saw h. **er** alive on **12-31** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis** Duration _____

Due to _____
Due to _____

Other conditions **J.B.H.**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy: **Pulmonary T.B. Intestinal T.B.**

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) _____ (e) Means of injury _____

23. Signature **William Smith** (M. D. or other) **0**
Address **Robert Koch Hospital** Date signed **1-5-42**

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

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.....

..... *myself* Registered Apprentice No.
working under my personal supervision.

Signed *William Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *2644 Volmer Bl.*

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, fact should be so stated above.