

No. 2
1-40
X23159

21060

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

BUREAU OF THE CENSUS
FILED JUL 20 1942

Registration District No. 266

Primary Registration District No. 5378

Registrar's No. 45

1. PLACE OF DEATH: Denn
 (a) County _____
 (b) City or town Rural - Walkington
 (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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Denn
 (c) City or town Walkington Township
 (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.? 0 years.

3. (a) PRINT FULL NAME Ada Olive Porter

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

4. Sex F 5. Color or race wh 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased Oct 3, 1870
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Home

11. Industry or business _____

12. Name Miriam Porter

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

14. Maiden name Mary Ellen Knaw

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

16. (a) Informant My Sister, Theresa

(b) Address Salem, Mo

17. (a) Burial (b) Date thereof 6-28-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arnett Cem

18. (a) Signature of funeral director Paul Eden

(b) Address Salem, Mo

19. (a) 6-28-42 (b) J. D. W. S.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 27
 year 1942 hour _____ minute 10-25 M.

21. I hereby certify that I attended the deceased from April 10 1939 to June 15 1942
 that I last saw her alive on June 15 1942
 and that death occurred on the 27 day and hour stated above.

Immediate cause of death Apoplexy

Due to Hypertension

Due to _____

Other conditions (Include pregnancy within 3 months of death) -430

Major findings: Of operations

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? Salem, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature J. D. W. S. (M. D. or other)
Address Salem, Mo Date June 28, 1942

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

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RECEIVED

District Health Officer No. 5.

District File Number 742403

Date Filed 7-17-72

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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.....

B. L. Murrel

Licensed Embalmer No. 3394

P. O. Address.....

Roller m

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21060

Registration District No. 266

Primary Registration District No. 5378

Registrar's No. 40

1. PLACE OF DEATH:

(a) County DeWitt
(b) City or town Rural
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ada Olive 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 WIDOWED

6. (b) Name of husband or wife GEO W PORTER 6. (c) Age of husband or wife if alive Not Living years

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

8. AGE: Years 71 Months 8 Days 3 (If less than one day _____) min. _____

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

10. Usual occupation _____

11. Industry of business _____

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) 10-26-42 (b) Jos Oliver
(Date received local registrar) _____ (Registrar's signature) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February year 1942 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

