

1995

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 9 1943

Registration District No. _____

Primary Registration District No. 4136

Registrar's No. 31-6

1. PLACE OF DEATH

(a) County Clinton
(b) City or town Plattsburg
(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 60 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton
(c) City or town Plattsburg
(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 Nellie Eliza Porter

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased Nov 10 1862
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>80</u> | <u>2</u> | <u>15</u> | hr. min. |

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

10. Usual occupation House wife

11. Industry or business Wm. Wells Smith

12. Name Wm. Wells Smith

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

14. Maiden name Ellen Cunningham

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

16. (a) Informant Mary C. Thomas

(b) Address Corner A & Line W. 2nd

17. (a) Burial (b) Date thereof 1-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plattsburg mo.

18. (a) Signature of funeral director O'Brien Ryan

(b) Address Plattsburg mo.

19. (a) Jan 30-43 (b) mo. C. Hartell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
year 1943 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan
_____ 1943 to Jan 1943
that I last saw her alive on Jan - 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemis 990

Due to Atherosclerosis of
coronary arteries
myocarditis

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

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following: 025

(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 P.M. Baker (M.D. or other) _____
Address Plattsburg Mo. Date signed 1-26-43

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

5030

1080

FEB 11 1943

STATE OF MISSISSIPPI

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 *Danell D. Lyon*

Licensed Embalmer No. *3640*

P. O. Address *Plattburg Mo.*

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. 7995-
Registrar's No. 31-

Registration District No. 74 Primary Registration District No. 4136

1. PLACE OF DEATH:
(a) County Clinton
(b) City or town Plattsburg
(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 Nellie Eliza 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 W

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 80 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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: _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ 19 _____
that I have seen him/her alive on _____ 19 _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration _____

Due to arterio sclerosis

acute nephritis 10 yrs

Due to myocarditis 2 wks

Other conditions _____

(Include pregnancy within 3 months of death)
ultra capsular fracture

Major findings: 8 months before death

Of operations _____

Of autopsy 1860

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) acc.

(b) Date of occurrence 8 mo before death

(c) Where did injury occur? Plattsburg, Clinton, Mo (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home (Specify type of place) _____ (e) Means of injury fall

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

DR. P. M. STECKMAN

OFFICE PHONE 147

U. S. REG. No. 3331

PLATTSBURG, MISSOURI

FOR *Mellie Eliza Porter*

DATE

ADDRESS

R

Mrs Porter had an intra-capsular fracture of her leg, about 8 months previous. She was in a cast for over 2 months, but did not show any symptoms of septicemia of any kind before that. She had endo- & pericardic murmurs, for several years.

*Very respectfully,
P. M. Steckman, M. D.*

TAKE THIS TO
PLATTSBURG DRUG CO.

The Rexall Store

PHONE 333 PLATTSBURG, MO.
NEXT TO POST OFFICE