

No. 2
M-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44225
Registrar's No. 5472

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days
(Specify whether years, months or days)

In this community 14 Days

3. (a) PRINT FULL NAME Porter Infant

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec 7th 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name W. O. Porter

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

14. Maiden name Marylin Barnes

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

16. (a) Informant W. O. Porter

(b) Address 3148 Central St

17. (a) Burial (b) Date thereof 12-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wagon Lawn Cem

18. (a) Signature of funeral director Marion P. Brown

(b) Address 200 Kan City mo

19. (a) 12-22-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3148 Central
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21
year 1943 hour 5 minute 55 A.M.

21. I hereby certify that I attended the deceased from December 7 1943 to December 21 1943
that I last saw him alive on December 21 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____

Due to _____

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:

(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 Drury R. Thom (M. D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 12-21-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 John D. Morton

Licensed Embalmer No. 4349

P. O. Address. No Kan City 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.