

FILED JAN 31 1945
Registration District No. **318**

Primary Registration District No. **1002** Registrar's No. **546**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Park Lane Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5544 Pershing
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary E. Porter

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, Divorced Widow

6. (b) Name of husband or wife Ephraim H. Porter

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

7. Birth date of deceased February 23 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

84	10	25	hr. min.
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9. Birthplace Henry County Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob Petzinger

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

14. Maiden name Unknown Kopp

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

16. (a) Informant Agnes Porter

(b) Address 5544 Pershing Ave.

17. (a) Removal (b) Date thereof 1-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JAN 18 1945 J. F. Bradesch
(Date received local Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18
year 1945 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1st 1945 to Jan 18th 1945
that I last saw her alive on 1-18, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Atherosclerosis
(8 days prior to death)

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)

Means of injury _____

23. Signature Oliver E. Kane (M. D. or other) MD

Address 766 Walton Date signed 1/18/45

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..... *Albert G. Hoppa*

Licensed Embalmer No..... *2971*

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, fact should be so stated above.