

FILED MAR 23 1945 318

Registration District No.

Primary Registration District No.

1003

State File No.

Registrar's No.

2403

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Brown Nursing Home 5564 Cabanne St  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 yr  
(Specify whether)  
 In this community 3 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 006  
17  
 (c) City or town ST LOUIS 9 5  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5564 CABANNE AV  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Price Porter

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

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, 2 divorced

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

7. Birth date of deceased Oct 13 - 1860  
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 29 If less than one day  
hr. min.

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

10. Usual occupation Actor

11. Industry or business \_\_\_\_\_

12. Name George Porter

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

14. Maiden name Mary Catherine Wilson

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

16. (a) Informant Mr. Richard Brown

(b) Address 7214 MARYLAND AV. U. City

17. (a) ~~Brown~~ (b) Date thereof 1-15-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Midtown MO

18. (a) Signature of funeral director Pitcher & Kuhne  
 (b) Address Midtown MO

19. (a) MAR 15 1945 (Date received local registration)  
J. F. Braddock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 12  
 year 1945 hour 11 minute 10 P.M.

21. I hereby certify that I attended the deceased from October, 1944, to March 12, 1945;  
 that I last saw him alive on March 10, 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease Duration 6-7 yr

Due to Chronic bronchitis & Emphysema

Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) 97

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 Keith Wilson (M. D. or other) MD  
 Address 4952 Maryland Date signed 3-12-45

WILIE PLAIN - USE ONLY

**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 Ketter*

Licensed Embalmer No. *3880*

P. O. Address. *St. Louis 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.**

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2403

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:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

James P. Porter

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

4. Sex M 5. Color or race W 6. (a) Single, (widowed, married, divorced) Widowed

6. (b) Name of husband or wife (Dink) 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 13 1866  
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) MAR 30 1945 (Date received local registrar) \_\_\_\_\_  
 (b) James J. F. Braddock (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 March 12  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; \_\_\_\_\_ 19\_\_\_\_;

that I last saw him \_\_\_\_\_ 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 \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A LEGIBLE COPY

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