

S. No. 2
DM-8-43
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25077

FILED AUG 11 1945

Registration District No. 217

Primary Registration District No. 3063

Registrar's No. 1993

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 hours
(Specify whether years, months or days)

In this community 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 18 Denver Place
(If rural, give location)

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

3. (a) PRINT FULL NAME LELIA PORTER

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased December 6 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	7	30	hr. min.

9. Birthplace Cave Inn Rock Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER

12. Name James H. Dossett

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

14. Maiden name Missouri Oldham

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

16. (a) Informant Lucille M. Thompson

(b) Address Webster Groves, Mo.

17. (a) Burial (b) Date thereof 8-8-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem

18. (a) Signature of funeral director Webster Groves
(b) Address Webster Groves 19 Mo

19. (a) 8-10-45 (b) C. S. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month August day 5th
year 1945 hour Eleven minute 35 P.M.

24. I hereby certify that I attended the deceased from August 5th 1945 to August 5th 1945
that I last saw her alive on August 5th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Diabetic Acidosis

Due to Cerebrovascular Accident

Due to 61

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 Carroll Hendrickson M. D. or other _____
Address 8-6-45 Date signed _____

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

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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 John M Meyer
Licensed Embalmer No. 3288
P. O. Address Kirkwood 77

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.