

FILED OCT 11 1945

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 269

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

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1700 Wardlow  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1700 Wardlow  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Minnie D Porter  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 8 day 28  
year 1945 hour 10 minute 40 P.M.

4. Sex Female 5. Color or race negro 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Wes Porter 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: (Month) 3 (Day) 24 (Year) 1889

21. I hereby certify that I attended the deceased from Sept 16, 1945 to Sept 28, 1945  
that I last saw her alive on Sept 25 and that death occurred on the date and hour stated above.  
Immediate cause of death: Cancer of Breast

8. AGE: Years 56 Months 5 Days 4 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations GO  
Of autopsy \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation House wife

11. Industry or business \_\_\_\_\_  
12. Name Bey Uplegrove  
13. Birthplace Mo (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name Garne Summers  
15. Birthplace Mo (City, town, or county) \_\_\_\_\_ (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Ms S H Byckner  
(b) Address 1700 Wardlow  
17. (a) Burial (b) Date thereof 9-2-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Robinson Cem  
18. (a) Signature of funeral director Geo E. Roberts  
(b) Address Hannibal Mo.  
19. (a) 9-14-45 (b) Dr. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] M. D. or other \_\_\_\_\_  
Address Hannibal Mo Date signed 9/14/45

**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 *Wes E Roberts*  
Licensed Embalmer No. 2113  
P. O. Address Hannibal

**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.**