

FILED NOV 14 1945

Registration District No. **14**

Primary Registration District No. **3016**

Registrar's No. **239**

1. PLACE OF DEATH:
 (a) County **Cole**
 (b) City or town **Jefferson City**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
509 Broadway St. rear-
(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) **2 1/2 months**

3. (a) PRINT FULL NAME **James Douglas Porting**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Child**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **August 19 1943**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	2	2	6	hr. 1 min.

9. Birthplace **Loosee Creek Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER
 12. Name **Raymond Porting**
 13. Birthplace **Loosee Creek Mo R.D.**
(City, town, or county) (State or foreign country)
 14. Maiden name **Marie Talken**
 15. Birthplace **Freeburg Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Raymond Porting**
 (b) Address **509 Broadway R. Jefferson City**
 17. (a) **Burial** (b) Date thereof **11-7-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Linn Mo**

18. (a) Signature of funeral director **Lelide Maston**
 (b) Address **Linn Mo**
 19. (a) **11-6-45** (b) **R. O. Darris MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Cole**
 (c) City or town **Jefferson City Mo**
(If outside city or town limits, write "RURAL")
 (d) Street No. **509 Broadway Rear**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **5**
 year **1945** hour **5** minute _____ p. M.

21. I hereby certify that I attended the deceased from **dead when viewed**
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiation by Drowning**
 Duration **a few minutes**
 Due to **fall in a well containing water**
 Due to _____

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

Major findings:
 Of operations _____
 Of autopsy _____
183.3
19

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) **Accident**
 Date of occurrence **11-5-45**
 (b) Where did injury occur? **Jeff city Cole Mo**
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **play** (Specify type of place) (c) Means of injury **Drowning**
 23. Signature **J. Leslie MD** (M. D. or other)
 Address **Jefferson city Mo** Date signed **11-6-45**

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

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 11-13-45

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 Victor Briesche

Licensed Embalmer No. 3701

P. O. Address Jefferson 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.