

FILED DEC 24 1946

Registration District No. **179**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1036 Broadway**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no.** (Specify whether)
In this community **20 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mrs. Amy Louise Porter**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **496-10-4562**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Percy Porter** 6. (c) Age of husband or wife if alive **dec.** years
7. Birth date of deceased **November 14 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 0 28 hr. min.

9. Birthplace **Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **Proof Reader**

11. Industry or business **The Kansas City Star**

12. Name **H. Z. Williams**

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

14. Maiden name **unknown,** (State or foreign country)

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

16. (a) Informant **Mrs. Oglesby**

(b) Address **3038 Grand Ave., Kansas City, Mo.**

17. (a) **Removal** (b) Date thereof **12-12-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Springfield, Missouri,**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **12-12-46** (b) **St. Thaddeus Helms**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3038 Grand Avenue**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **11**
year **1946** hour **1:00** minute **A. M.**

21. I hereby certify that I attended the deceased from **Dec 4 1945**
to **Dec 4 1946**
that I last saw her alive on **Dec 4 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **Hypotension & high blood pressure**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **830**
Of autopsy

Duration
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?

(Specify type of place) While at work? (c) Means of injury

23. Signature **Dr. W. G. ...** (M. D. or other)
Address **W. G. ...** Date signed **12-11-46**

MOTHER FATHER

Dr. Migno

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 *[Signature]*
Licensed Embalmer No. *1415*
P. O. Address *14 E. 17th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.