

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 19 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19969

Registration District No. 374

Primary Registration District No. 6272

Registrar's No. 46

1. PLACE OF DEATH:

(a) County: Worth
(b) City or town: Rural
(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: 60 yrs. (Specify whether
In this community: 60 yrs. years, months or days)

3. (a) PRINT FULL NAME: HARVEY ALEXANDER PORTER

3. (b) If veteran, name war: no 3. (c) Social Security No. ✓

4. Sex: MD 5. Color or race: W 6. (a) Single, widowed, married, divorced: divorced
6. (b) Name of husband or wife: Mollie Porter 6. (c) Age of husband or wife if alive: 79 years
7. Birth date of deceased: Feb 16 1864 (Month) (Day) (Year)

8. AGE: Years: 83 Months: 2 Days: 11 If less than one day: hr. min.

9. Birthplace: Gracer Co. Virginia (City, town, or county) (State or foreign country)

10. Usual occupation: farmer

11. Industry or business:

12. Name: Minatell Porter
13. Birthplace: Taswell Co. Virginia (City, town, or county) (State or foreign country)
14. Maiden name: Guth Phipps
15. Birthplace: Gracer Co. Virginia (City, town, or county) (State or foreign country)

16. (a) Informant: Wm. Porter
(b) Address: Abing, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-28-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Freelands Cemetery

18. (a) Signature of funeral director: John C. Duffel

(b) Address: Grant City, Mo.

19. (a) May 7 1947 (Date received local registrar) (b) Heta E. Duverson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Worth 11.3
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: Grant City, MO. 0 (If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country: ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 4 day: 26 year: 47 hour: 6 minute: 30 A.M.

21. I hereby certify that I attended the deceased from 3-2 1947 to 4-26 1947, that I last saw him alive on 4-26 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: blastomycosis Duration: 6 mo.

Due to: ✓ Due to: ✓

Other conditions: Highly infected / several lesions 3x
(Include pregnancy within 3 months of death)

Major findings: 13
Of operations: ✓
Of autopsy: ✓

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: 0

23. Signature: B. J. Hoss MD (M.D. or other) Address: Grant City, Mo. Date signed: 4-27-47

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Arch C. Duffee

Licensed Embalmer No. 3252

P. O. Address. Grant 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.