

No. 2
2-45
7-30
X47970

FILED MAR 20 1948

Registration District No. 274

Primary Registration District No. 30.52

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1401 N. Osage 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 34 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 1401 N. Osage
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lucy Bryant Porter
3. (b) If veteran, name war _____
3. (c) Social Security No. 489-20-0032

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced 2 divorced, widowed
6. (b) Name of husband or wife Charles
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 1 10 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 1 19 hr. min.

9. Birthplace: Unknwn
(City, town, or county) (State or foreign country)

10. Usual occupation Janitress

11. Industry or business _____

MOTHER FATHER
12. Name Peter O'Bryant
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. William Hubbard
(b) Address 110 E. Hamm St. - Sedalia, Mo.

17. (a) Burial (b) Date thereof 3-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Glennwood Cemetery, Sedalia, Mo.

18. (a) Signature of funeral director J. Price Alexander
(b) Address 400 W. Cooper St. - Sedalia, Mo.

19. (a) 3-4-48 (b) Betty Yeager
(Date received local registrar) (Registrar's signature)
2510 (Licensed Embalmer's Signature on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1948 hour 2 minute 9 M.
21. I hereby certify that I attended the deceased from 93 Cooper
March 2, 1948, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 4 Day

Due to exposure

Due to _____

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

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL PHYSICIAN SUPPLEMENTAL INFORMATION REQUESTED

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 2

23. Signature Dr. J. D. Golden (M.D. or other) Dr.
Address 215 E. 2nd Sedalia, Mo. Date signed 3/4/48

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-19-42

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 _____

Licensed Embalmer No. 4248

P. O. Address. So. Lake St. 42

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.

Registration District No. 274 Primary Registration District No. 3052

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(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 _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Lucy B. Porter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B
6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 10 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days _____ (If less than one day, _____ min)

9. Birthplace _____ (City, town, or county) (State or foreign country) Ind

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb Day 29 Year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to _____

Due to _____

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

Major findings: 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 _____

23. Signature _____ (M. D. or other) Dio

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

1206-5