

S. No. 2
M-5-43
v. 5-17-39
1 X36671

FILED DEC 7 1948

Registration District No. 570

Primary Registration District No. 6258

State File No. _____

Registrar's No. 16

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

1. PLACE OF DEATH:

(a) County Wayne

(b) City or town Greenfield 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 _____ (Specify whether _____)
In this community 40 years (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME JOE GAINES PORE

3. (b) If veteran, name war W.W.I

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, ~~widowed~~, married, divorced SD

6. (b) Name of husband or wife _____

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

7. Birth date of deceased APRIL 9 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

60 5 25 hr. min.

9. Birthplace Sulphur Well Ky 1
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business limestone

12. Name Benjamin Pore

13. Birthplace Ky 1
(City, town, or county) (State or foreign country)

14. Maiden name Ateneia Wallace

15. Birthplace Ky 1
(City, town or county) (State or foreign country)

16. (a) Informant Bertie Pore

(b) Address Greenfield - Mo

17. (a) Burial (b) Date thereof 10 6/1948
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place of burial or cremation Wayne Greenfield Cem

18. (a) Signature of funeral director M. Marshall

(b) Address Greenfield - Mo

19. (a) Dec 4th - 48 (b) Mabel Beasley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wayne 18

(c) City or town Greenfield Rural 3
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4
year 1948 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 10
minutes

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 830

Major findings: Of operations _____

Of autopsy none no

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? _____

While at work _____ (Specify type of place)

(e) Means of injury Car

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

Address Greenfield Date signed 10/6/48

RECEIVED

Health Officer No. 4

Number 1248-1512

Date 12-6-48

DEC 7 1948

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.....

[Signature]

Registered Apprentice No.

working under my personal supervision.

Signed.....

[Signature: T. S. Marshall]

Licensed Embalmer No. 4601

P. O. Address. Quincy

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.