FILED SEP 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31075

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 301

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hannibal
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Elizabeth Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Marion
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hannibal
d. STREET ADDRESS (If rural, give location): 1500 Vermont St

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Joseph.
c. (Last): Porter

4. DATE OF DEATH (Month) (Day) (Year): Aug. 31. 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: December 23 1875
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months ~~8~~ Days ~~8~~ — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soap Manufacture
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY?: USA.

13a. FATHER'S NAME: John Porter.
13b. MOTHER'S MAIDEN NAME: Unknown.
14. NAME OF ~~HUSBAND~~ OR WIFE: Alice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Alice Porter 1500 Vermont Hannibal Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of Stomach

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Cachexia

INTERVAL BETWEEN ONSET AND DEATH: 151X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-27, 1949, *to* 8-31, 1949, *that I last saw the deceased alive on* 8-31, 1949, *and that death occurred at* 4:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: 1001 Bldg Hannibal Mo
23c. DATE SIGNED: 9/9/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-2-49
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
24d. LOCATION (City, town, or county) (State): Hannibal Marion MO

DATE REC'D BY LOCAL REG.: 9-12-49
REGISTRAR'S SIGNATURE: By WC Fisher Dr. E. M. Lucke Deputy
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James O'Donnell Hannibal MO

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Michael J. O'Donnell

Licensed Embalmer No. 3246

P. O. Address Hannibal Mo

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.