

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29334

1. PLACE OF DEATH

County Buchanan
 Township
 City St. Joseph

Registration District No. 1001
 Primary Registration District No. 1001
 (No. Noyes Hospital)

File No. _____
 Registered No. 1086
 St. _____ Ward

2. FULL NAME Newton Calvin Proctor

(a) Residence. No. 2207 South 3rd St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grace G. Proctor,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 9th. 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
39 | 8 | 2 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife,
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Savannah,
 (STATE OR COUNTRY) Missouri.

10. NAME OF FATHER William J. Proctor,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Taney County,
 (STATE OR COUNTRY) Missouri.

12. MAIDEN NAME OF MOTHER Belle Coulson,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Harrison Co.,
 (STATE OR COUNTRY) Missouri.

14. INFORMANT Mrs. C. G. Proctor
 (Address) 2207 South 3rd Street.

15. FILED 10 10 25 Geo. Harrison
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 11, 1925

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1925 to Oct. 11, 1925
 that I last saw him alive on Oct. 11, 1925, and that death occurred, on the date stated above, at 11:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute suppurative ap-
pendicitis
perforated
peritonitis
 (duration) _____ yrs. _____ mos. 7 ds.

CONTRIBUTORY (SECONDARY) General Peritonitis and Septicemia
 (duration) _____ yrs. _____ mos. 7 ds.?

18. WHERE WAS DISEASE CONTRACTED near Amazonia Mo
 IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF Oct 6 - 1925WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? operation
 (Signed) W. J. Grew M. D.

10/11, 1925 (Address) St. Joseph Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Amazonia, Missouri. DATE OF BURIAL Oct. 13, 1925

20. UNDERTAKER Heaton-Begala Und. Co. ADDRESS 315 S. 10th. S.

by J. M. Kaul

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS,
BY PHYSICIAN.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County..... Douglas Registration District No. 85 File No. 29334
 Township..... Primary Registration District No. 1001 Registered No. 1086
 City..... St Joseph (No. Royal Hospital) St. Ward)

2. FULL NAME..... Newton Calvin Proctor

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grace Proctor

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-6-1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 8 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 10-12-23 Eva Harrison REGISTRAR
J. S. U.

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 19 25

17. I HEREBY CERTIFY, That I attended deceased from to
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL, 19.....
 ADDRESS

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRATION SHAI 5 A FILE F CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 10 b. stated inspec. Exact statement of OCCUPATION is very important.

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