

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

Do not use this space.

20061

PLACE OF DEATH

County Miles
Township Saline
City Olean (No. _____)

Registration District No. 561
Primary Registration District No. 2755

File No. _____
Registered No. 35
St. _____ Ward _____

2. FULL NAME

Emma Proctor

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
About 65

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) Moniteau Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Elisha Hickox

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

12. MAIDEN NAME OF MOTHER Sally Latham

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

14. INFORMANT Herman W Proctor
(Address) Olean

15. FILED 6-5-30 Belle Haynes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 5 1930

17. HEREBY CERTIFY, That I attended deceased from June 1 1930 to June 5 1930 that I last saw her alive on June 4 1930, and that death occurred, on the date stated above, at 6:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy
131
820
108 (duration) yrs. mos. 4 ds.
CONTRIBUTORY Chronic Nephritis
(SECONDARY) Myocardial
(duration) 1 yrs. mos. ds.

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) W. L. Allen M.D.
Eldon Mo.
. 19 (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Moniteau Cemetery Moniteau Co. DATE OF BURIAL 6-6 1930

20. UNDERTAKER W A Phillips ADDRESS Eldon Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUL 23 1930

