

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

Do not use this space.
21530

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. City Sanitarium.....) St. (Ward).....

File No.
Registered No. **6717**

2. FULL NAME *Frank Robert X. Proffit*

(a) Residence. No. St. **13** Ward. **Lesterville, Mo.**
(Usual place of abode) (If nonresident, give city or town and State)

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.

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
Julia Proffit

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **1884-3-30**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	44	2	28	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) **Reynolds County,**
(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **John Proffit**

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

12. MAIDEN NAME OF MOTHER **Grace St. John**

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

14. INFORMANT **Julia Proffit,**
(Address) **Kock, Mo.**

15. **JUL 21 1930** Max O. Starkey
FILED..... 19..... REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6/28/30.** 19.....

17. *To My Successors*
I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at **4:30 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Strangely (shock) while suffering temporary mental aberration
165 (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) *suicide*
(duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *John J. Hurley* M.D.

7/8, 1930 (Address) *Deputy Coroner*

*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 DATE OF BURIAL

Lesterville, Mo. **7/11 1930**

20. UNDERTAKER ADDRESS

Robert... **457**

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.

**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..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 6717
 City..... (No. Sanitarium) St. Ward)

2. FULL NAME Robert Frank Proffitt
 (a) Residence. No. Lestersville Mo. 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. 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 Julia Proffitt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/4 or 4/5 or 1st week

7. AGE YEARS MONTHS DAYS | **IF LESS than 1 day,** hrs. or min.
44 or 45 | 1st | or | March | 1st

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

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

10. NAME OF FATHER John Proffitt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
 (STATE OR COUNTRY)

14. INFORMANT Mrs Julia Proffitt
 (Address) 330 N. Shaffer St. Orange Co. Mo.

15. FILED 7-1931 man Starkloff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 1930

17. I HEREBY CERTIFY, That I attended deceased from....., 19.....
 to....., 19.....
 that I last saw h..... at..... on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
 (duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY).....
 (duration)..... 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)....., M. D.

, 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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-21530