

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

Do not use this space.

1. PLACE OF DEATH

County Jefferson
Township Union
City Grant City (No.)

Registration District No. 704
Primary Registration District No. 6210

File No. 16963
Registered No.
St. Ward)

2. FULL NAME Morris D. Proctor

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

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

Arny Mave Proctor

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 22, 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. min.
57 8 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Central Hill
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER James L. Proctor

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

12. MAIDEN NAME OF MOTHER Ann P. Proctor

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

14. INFORMANT M. J. Proctor
(Address) Grant City, Mo.

15. FILED 4-16-1931 Laura Johnson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14 1931

17. I HEREBY CERTIFY, That I attended deceased from March 12 1931, to April 14 1931, that I last saw him alive on April 14 1931, and that death occurred, on the date stated above, at 10:00 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertensive heart disease

CONTRIBUTORY (SECONDARY) 95 B

18. WHERE WAS DISEASE CONTRACTED 95 B
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Spinal fluid

(Signed) J. H. Rose, M. D.

, 19 31 (Address) Grant City, 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.

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

Mt. Vernon Cemetery 4-17-1931

20. UNDERTAKER Arch C. Dumble ADDRESS Grant City

