

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

44847

Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 837
 (b) Township Castor Primary Registration District No. 6099 45 18 Registered No.
 (c) City Bloomfield, Mo. (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 616 Lelia C. Proffer

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marion W. Proffer (Dec)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 11 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee.

FATHER 13. NAME James D. Cousins

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee.

MOTHER 15. MAIDEN NAME Sarah Green

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT Earl A. Proffer
 (ADDRESS) Dupo, Illinois.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lick Creek cem. DATE Dec. 12, 1939

19. FUNERAL DIRECTOR (NAME) Chiles Und. Co.
 (ADDRESS) Bloomfield, Mo.

20. FILED Dec. 20, 1939 Sonnie Punch
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1939 to Dec 11, 1939
 I last saw h. or alive on Dec 11, 1939. Death is said to have occurred on the date stated above, at 4:15 a. m.
 The principal cause of death and related causes of importance were as follows:

Chronic myocarditis and myocardial degeneration Date of onset ?

Other contributory causes of importance: Ashtoria ?

Name of operation None Date of
 What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify
 (Signed) J. H. Jones, M. D.
 (Address) Bloomfield, Mo.

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X16605

RECEIVED

District Health Officer No. 2

District File Number 140-495

Date Filed 1-9

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P.O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.