

V. S. No. 2  
FORM-2-43  
Rev. 5-17-39  
I X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27445

State File No. \_\_\_\_\_

ED AUG 27 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3611

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Kansas City General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

In this community 11 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Phillip Proctor

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. Aug 6 1943  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace K.C. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm H Proctor

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Taylor

15. Birthplace mo A  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm H Proctor

(b) Address 3109 1/2 E 18 St

17. (a) Burial (b) Date thereof Aug 21-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Haven

18. (a) Signature of funeral director Wm C R Foster

(b) Address 914 Brooklyn

19. (a) 8-21-43 (b) T. B. Benson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 3109 1/2 E. 18 St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18  
year 1943 hour 10 minute 20 P. M.

21. I hereby certify that I attended the deceased from August 17, 1943 to August 18, 1943  
that I last saw him alive on August 18, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Breast Abscess  
Impetigo Contagiosa

Due to \_\_\_\_\_

Due to 153!?

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy See above

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature Dwight R. Thorne (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 8-20-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 David C. Browning  
Licensed Embalmer No. 2724  
P. O. Address H. C. Mo

**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, fact should be so stated above.**