S. No. 2
M—8-43
. 5-17-39
p I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18347
State File No.

Registration District No. 32 4 — Primary Registration District No. 30 72 — Registrar's No. 83

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution all his life (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Marshall (If outside city or town limits, write "RURAL")
(d) Street No. 352 East Pond (If rural, give location)
(e) Citizen of foreign country? [redacted] (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Ford Proffitt
3. (b) If veteran, name war —
3. (c) Social Security No. —

MEDICAL CERTIFICATION

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 December 18 1869 (Month) (Day) (Year)

20. DATE OF DEATH: Month May day 13th year 1945 hour 07 minute 709 A.M.
21. I hereby certify that I attended the deceased from Jan 10, 1945 to May 13, 1945 that I last saw him alive on May 12, 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 75 | Months 5 | Days 3 | If less than one day — hr. — min.

Immediate cause of death — Duration
Due to Pul. Tuberculosis 2yr
Due to —
Due to —
Other conditions (Include pregnancy within 3 months of death) None

9. Birthplace Near Cyres Saline Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business —

FATHER
12. Name John Proffitt
13. Birthplace Don't know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Helen Mae Ford
15. Birthplace Don't know (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Albert Burch
(b) Address Slater Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof J-15-45 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ High Hill Ryan Slater Mo

18. (a) Signature of funeral director Jones & Jupe
(b) Address Slater Mo

19. (a) 5/14/1945 (Date received by local registrar) (b) P.O. Westbrook Asst. (Registrar's signature)

PHYSICIAN

Major findings:
Of operations —
Of autopsy 13 hr

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? (Specify type of place)
(e) Means of injury
while at work

23. Signature [redacted] (M. D. or other)
Address Marshall Mo Date signed 5/14/45

12 15

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District Filo Number ----------
Date Filed ---------- 6/12/45

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 Jas E Jones

Licensed Embalmer No. 3143

P. O. Address Slater 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.