FILED MAR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4671

BIRTH NO. _____ REG. DIST. NO. 132 PRIMARY REG. DIST. NO. 4203 Registrar's No. 210

1. PLACE OF DEATH
a. COUNTY Grundy
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Galt
c. LENGTH OF STAY (in this place) /
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Galt Mo b. COUNTY Grundy
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Galt
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) FRANCES c. (Last) PROFFITT

4. DATE OF DEATH (Month) Feby (Day) 17 (Year) 1949

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Holt Mo
12. CITIZEN OF WHAT COUNTRY? U S A.

13a. FATHER'S NAME William Proffitt
13b. MOTHER'S MAIDEN NAME Sarah Kitchen
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mrs Myrtle Baker ADDRESS Galt Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 6 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 15th, 19 49, *to* Feb 17th, 19 49 *that I last saw the deceased alive on* Feb 17th, 19 49 *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Clinton F. Duffy M.D. (Degree or title)
23b. ADDRESS Newton Mo
23c. DATE SIGNED Feb 18th 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Feby 20-49
24c. NAME OF CEMETERY OR CREMATORY Rural Dale cem
24d. LOCATION (City, town, or county) (State) Trenton Mo Rural

DATE REC'D BY LOCAL REG. Feb 18, 1949
REGISTRAR'S SIGNATURE Irene Fair
25. FUNERAL DIRECTOR'S SIGNATURE O K Payne & Son ADDRESS Galt Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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_____, Student Embalmer No. _____ working under my personal supervision.

Signed P. K Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

Signed _____
Student Embalmer

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

If this body is not embalmed, fact should be so stated above.