

FILED AUG 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22744

BIRTH NO.		REG. DIST. NO. 47	PRIMARY REG. DIST. NO. 3008	Registrar's No. 260
1. PLACE OF DEATH a. COUNTY Calloway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Marion		
b. CITY (If outside corporate limits, write RURAL and give township) Fulton		c. LENGTH OF STAY (In this place) 2 1/2 mo 3 1/2		c. CITY (If outside corporate limits, write RURAL and give township) 64 Palmyra
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No 1		d. STREET ADDRESS (If rural, give location) 60		
3. NAME OF DECEASED (Type or Print) a. (First) Lorena b. (Middle) Boyd c. (Last) Proctor		4. DATE OF DEATH (Month) (Day) (Year) Aug 1 1949		
5. SEX F	6. COLOR OR RACE white	7. MARRIED (NEVER MARRIED, WIDOWED, DIVORCED) (Specify) never married	8. DATE OF BIRTH March 14 1892	9. AGE (In years last birthday) 57 Months 4 Days 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? American
13a. FATHER'S NAME J. W. Proctor		13b. MOTHER'S MAIDEN NAME Evelyn Hopton	14. NAME OF HUSBAND OR WIFE none	
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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS State Hosp No 1/Reverend Fulton Mo	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia 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.		INTERVAL BETWEEN ONSET AND DEATH 3 days 491X
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from July 23, 1949, to Aug 1, 1949, that I last saw the deceased alive on Aug 1, 1949, and that death occurred at 8:00 a.m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) J. L. Price D. No		23b. ADDRESS State Hosp No 1, Fulton Mo		23c. DATE SIGNED 8-1-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/1/49	24c. NAME OF CEMETERY OR CREMATORY Palmyra	24d. LOCATION (City, town, or county) (State) Marion County Mo
DATE REC'D BY LOCAL REG. Aug 1-1949		REGISTRAR'S SIGNATURE 426 Maretta Lawrence		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Glen Y. Marjain, Fulton Mo

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

(Licensed Embalmers' Statement on Reverse Side)

District File Number _____
District Health Officer No. 9,
AUG 9 1919 RECEIVED

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.

Student
Student Embalmer

Signed _____

J. J. Ross

Licensed Embalmer No. 2555

P. O. Address Fulton 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.