

FILED AUG 19 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28654

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 111

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SIXESTON	c. LENGTH OF STAY (in this place) SOA.	c. CITY OR TOWN SIXESTON	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION DELTA COMM HOSP		STREET ADDRESS (If rural, give location) 913 LORA 10030	

3. NAME OF DECEASED (Type or Print) a. (First) LORENE b. (Middle) ESTELLE c. (Last) PROFFER	4. DATE OF DEATH (Month) (Day) (Year) 7-28-1955
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9-10-1914	9. AGE (In years last birthday) 40	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) SCHOOL TEACHER	10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS	11. BIRTHPLACE (City and State or Foreign Country) ADVANCE MO	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME ALBERT C. GOZA	13b. MOTHER'S MAIDEN NAME AMANDA DAVIS	14. NAME OF HUSBAND OR WIFE LEE C. PROFFER
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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 LEE C. PROFFER ADDRESS Sixeston MO
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 min?
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fr. of 7th cervical vertebrae		
	ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrown from horse		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E845X 21		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Stodard Co. Farm	21c. (CITY, TOWN, OR TOWNSHIP) Stodard MO (STATE) MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 28 1955 6:00 P.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? fell off horse, hitting neck on tree root.
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22. I hereby certify that I attended the deceased from about 19, to 19, that I last saw the deceased alive on 19, and that death occurred at about 6:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas C. Buckthorpe, M.D. Health Officer	23b. ADDRESS Benton MO	23c. DATE SIGNED 7-29-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7-31-55	24c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES	24d. LOCATION (City, town, or county) (State) SIXESTON MO
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DATE REC'D BY LOCAL REG. 8-12-55	REGISTRAR'S SIGNATURE Mr. Otha Hunter 429	25. FUNERAL DIRECTOR'S SIGNATURE Welsh Funeral Home-Sixeston MO ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DATE RECEIVED AUG 15 1955

SCOTT CO. HEALTH DEPT.

OO, FILE No. 855-173

VS APR 21 1960

FEB 29 1956

VS JAN 2 1960

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 _____
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 340

P. O. Address Keaton

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.