

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40823**

FILED DEC 28 1955

5170

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>                                   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>Johnson</b> |   |
| b. CITY OR TOWN <b>KANSAS CITY</b>  | c. LENGTH OF STAY (in this place) <b>25 days</b> | c. CITY OR TOWN <b>WARRENSBURG, MISSOURI</b>   | d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b> |  | f. STREET ADDRESS (If rural, give location) <b>ROUTE 3</b>   |   |

|                                     |                          |                            |                        |  |
|-------------------------------------|--------------------------|----------------------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>CONRAD</b> | b. (Middle) <b>EARNEST</b> | c. (Last) <b>PROFT</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>November 26, 1955</b> |
|-------------------------------------|--------------------------|----------------------------|------------------------|--|

|                    |                               |   |  |   |   |  |
|--------------------|-------------------------------|---|--|---|---|--|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH <b>April 26, 1890</b> | 9. AGE (in years last birthday) <b>65</b> | if UNDER 1 YEAR Months _____ Days _____ | if UNDER 24 HRS. Hours _____ Mins. _____ |
|--------------------|-------------------------------|---|--|---|---|--|

|   |   |   |  |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber, Retired</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Corning, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b> |
|---|---|---|--|

|                                      |   |  |
|--------------------------------------|---|--|
| 13a. FATHER'S NAME <b>JOHN PROFT</b> | 13b. MOTHER'S MAIDEN NAME <b>MAGDALENE LEHMAN</b> | 14. NAME OF HUSBAND OR WIFE <b>Augusta</b> |
|--------------------------------------|---|--|

|  |                                     |  |               |
|--|-------------------------------------|--|---------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b> | 16. SOCIAL SECURITY NO. <b>none</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Official VA Hospital Records, KC, MO.</b> | ADDRESS _____ |
|--|-------------------------------------|--|---------------|

|  |  |                                |  |  |
|--|--|--------------------------------|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION          |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b> |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Purulent meningitis</b>  |  | DUPLICATE (2-2-55)             |  |  |
| *This does not mean the mode of dying, such as heart failure, athermia, etc. It means the disease, injury, or complication which caused death. |  | ANTECEDENT CAUSES              |  |  |
|  |  | DUE TO (b) _____               |  |  |
|  |  | DUE TO (c) _____               |  |  |
| II. OTHER SIGNIFICANT CONDITIONS   |  | Arteriosclerotic heart disease |  | 3403   |
| 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 <input checked="" 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) <b>VA</b> | 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 **November 1, 1955**, to **November 26, 1955**, and that death occurred at **1:46 Pm.**, from the causes and on the date stated above.

|  |   |                                  |
|--|---|----------------------------------|
| 23a. SIGNATURE <b>Joaquin F. Lopez MD</b> (Degree or title) <sup>D</sup> | 23b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b> | 23c. DATE SIGNED <b>11-27-55</b> |
|--|---|----------------------------------|

|   |                            |  |  |
|---|----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> | 24b. DATE <b>NOV-28-55</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN CEM</b> | 24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY Mo.</b> |
|---|----------------------------|--|--|

|  |   |  |  |
|--|---|--|--|
| DATE REC'D BY LOCAL REG. <b>11-28-55</b> | REGISTRAR'S SIGNATURE <b>Neval Marshall</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>D.W. Newcomer Sons</b> | ADDRESS <b>1337 1/2 Broadway Corcoran R.C. Mo.</b> |
|--|---|--|--|

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 *Edward M. A.*

Licensed Embalmer No. ....

P. O. Address *K.C. Ill*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitute's 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.