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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008964
STATE FILE NUMBER
298

FILED MAR 24 1958

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 298

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> <u>0112</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2328 Mitchell Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBERTA</u> Middle <u>YVONNE</u> Last <u>PROFFIT</u>			4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1958</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1935</u>
9. AGE (In years last birthday) <u>22</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>control meter operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stenography</u>	11. BIRTHPLACE (City and state or country) <u>Craig, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Stanford Burge</u>		13b. MOTHER'S MAIDEN NAME <u>Myrtle Walden</u>	14. NAME OF HUSBAND OR WIFE <u>Gerald Proffit</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>497-38-4866</u>	17. INFORMANT Address <u>Mrs. Myrtle Burge, Savannah, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, Acute Toxic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Secondary to Anoxia & Pneumonia</u>			<u>3/1/58</u>
DUE TO (c) <u>Secondary to Ruptured Ectopic Preg.</u>			<u>2/26/58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>with severe internal hemorrhage</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>ITEM 3 CORRECTED</u>	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		BY AFFIDAVIT OF <u>Husband</u> <u>3-6-59</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Feb. 25, 1958</u> to <u>March 13, 1958</u> last saw her alive on <u>March 13, 1958</u> Death occurred at <u>1:56</u> P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert A. Kieber, M.D.</u> (Degree or title)		22b. ADDRESS <u>St. Joseph, Mo</u>	22c. DATE SIGNED <u>3/14/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 15, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>W. A. Rich</u>		ADDRESS <u>Savannah, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 14, 1958</u>
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Handell</u>			

SEP 18 1954

SEP 16 1954

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 *Wm A Reich* _____

Licensed Embalmer No. 4728
P. O. Address Savannah, Ga

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.