

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020632

Registration District No. 53 Primary Registration District No. 3010 STATE FILE NUMBER
Registrator's No. 205

1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>CAPE GIRARDEAU</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CHAFFEE</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>CAPE OSTEOPATHIC HOSP.</u>		Length of stay in 1b <u>6 HRS.</u>	d. STREET ADDRESS (If outside, give location) <u>124 BLACK AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGIA BENNIE PROCTOR</u>			4. DATE OF DEATH Month Day Year <u>MAY 28, 1959</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>MARCH 5, 1898</u>
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months Days <u>2 23</u>	IF UNDER 24 HRS Hours Min. <u>2 33</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>BENTON, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>CHARLES ALBERT REDFERN</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY LOU BIRD</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH DUDLEY PROCTOR</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>NONE</u>	
17. INFORMANT <u>JOSEPH D. PROCTOR - CHAFFEE, MO.</u>		Address	
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>Shock</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Thrombosis</u>			<u>5 hrs.</u>
DUE TO (c) <u>Atherosclerosis</u>			<u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus, labile</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT 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>6-17-58</u> to <u>5-28-59</u> and last saw her alive on <u>5-27-59</u> Death occurred at <u>4:15</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. H. Schmeyer, D.O.</u>		22b. ADDRESS <u>Chaffee, mo</u>	
22c. DATE SIGNED <u>6/1/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 30, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CHAFFEE, MISSOURI</u>
24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME - CHAFFEE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-10-1959</u>	26. REGISTRAR'S SIGNATURE <u>Dorene Kasten</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Jack T. Burnett*

Licensed Embalmer No. *4473*

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