

# FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1959

59-039253

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Carrollton</b>		Length of stay in 1b <b>35 yrs.</b>	c. CITY OR TOWN <b>Carrollton</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>112 N. Main</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>BENJAMIN HUBERT PROFFITT</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/28/1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Maintenance</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	11. BIRTHPLACE (City and state or country) <b>Lakeview, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Benjamin S. Proffitt</b>	13b. MOTHER'S MAIDEN NAME <b>Cyrena Jane Leaky</b>	14. NAME OF HUSBAND OR WIFE <b>Anna L. Proffitt</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>500-07-5021</b>	17. INFORMANT <b>Delbert Proffitt, Carrollton, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis &amp; chronic prostatitis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <b>4:15 P.</b> Month, Day, Year <b>15 Nov 59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Carrollton</b>	COUNTY <b>Mo.</b>	STATE
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21. I attended the deceased from <b>1958</b> to <b>15 Nov 59</b> and last saw her alive on <b>15 Nov 59</b> Death occurred at <b>4:15 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>E W Allen</b> (Degree or title)	22b. ADDRESS <b>MD Carrollton</b>	22c. DATE SIGNED <b>17 Nov 59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/18/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cem.</b>	23d. LOCATION (City, town, or county) <b>Carrollton Mo.</b>
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24. FUNERAL DIRECTOR <b>Gibson Funeral Home, Carrollton, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-18-59</b>	26. REGISTRAR'S SIGNATURE <b>Tom Norbert Calver</b>
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**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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.