MAY 24 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 10081 16

Registered No.

1. PLACE OF DEATH

County: Dade

Township: Center

City: Greenfield (No. ..... St. ..... Ward)

Registration District No. 237

Primary Registration District No. 4144

2. FULL NAME Ethel Naomi Proctor

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 19 - 1910

7. AGE	Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
	18	6	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk State Dept. Enrolling Room

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Moline
(STATE OR COUNTRY) Kansas

PARENTS

10. NAME OF FATHER Tom Proctor

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Dade Co Mo

12. MAIDEN NAME OF MOTHER Dairy Ralston

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

14. INFORMANT Tom Proctor
(Address) Greenfield Mo

15. FILED 4-9, 1929 E. O. Ball
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 26 1929

17. I HEREBY CERTIFY, That I attended deceased from as 23, 1927, to Mar 26, 1927 that I last saw him alive on Mar 26, 1929, and that death occurred, on the date stated above, at 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Traumatic meningitis
1924 B

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) None

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) T. D. Bennett, M. D

, 19 (Address) Greenfield

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Greenfield Cemetery — DATE OF BURIAL: Mar 28 1929

20. UNDERTAKER: J. W. Ward — ADDRESS: Greenfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.