

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

Do not use this space.

DEC 20 1937

40507

1. PLACE OF DEATH

County Jackson
Township 15th
City Kansas

Registration District No. 399
Primary Registration District No. 1002
(No. 200 W 4th)

File No. _____
Registered No. 40507
St. _____ Ward _____

2. FULL NAME

Herman Proe

(a) Residence, No. 200 W 4th St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Do not know

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 18 54

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 — — —

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know

13. NAME Do not know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know

15. MAIDEN NAME Do not know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know

17. INFORMANT Caroline Proe (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Lansburg Mo. DATE Nov. 30 - 37

19. UNDERTAKER San Antonio Bros (ADDRESS) K. C. Mo.

20. FILED Nov 30 1937 M. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 29 1937

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____. I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, 2:40 P. m.

The principal cause of death and related causes of importance were as follows: Fracture of the skull. Date of onset _____

Other contributory causes of importance: _____
W

Name of operation _____ Date of _____
What test confirmed diagnosis _____ Was there an autopsy? Yes

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide Predominant Date of injury 11/24/37
Where did injury occur? Do not know (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury Fell but do not know
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) [Signature] _____, M. D.
(Address) [Signature]

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.

