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.

SEP 18 1939

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

41134
Do not use this space.

1. PLACE OF DEATH
(a) County WRIGHT Registration District No. 907
(b) Township PLEASANT VALLEY Primary Registration District No. 6220 Registered No. 21
or
(c) City ..... (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 1 yrs. 1 mos. 25 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 6 2 D Dorothy May Prock
(a) Residence, No. ..... St. ..... (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 18-1938
7. AGE Years 1 Months 1 Days 25 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child.
9. Industry or business in which work was done, as 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) Mansfield Mo.

FATHER
13. NAME Thomas B. Prock
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ava Mo.

MOTHER
15. MAIDEN NAME Almeda A. Nelson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hobart Okla.

17. INFORMANT (ADDRESS) Thomas B. Prock Mansfield Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mansfield Cem. DATE Nov 14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Steffe Funeral Home Mansfield Mo.

20. FILED Nov 1 1939 J. M. D. Short
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 13 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1939, to Nov 13, 1939
I last saw her alive on Nov 12, 1939 Death is said to have occurred on the date stated above, at 3 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia	

Other contributory causes of importance:
Cold

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) L. J. Vaynor, M. D.
(Address) Norwood Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File No. 1239-22427
Date Filed DEC 5 1939

1072

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~~ ....., Registered Apprentice No. ..... working under my personal supervision.

Signed F. A. Stiffe

Licensed Embalmer No. 3221

P. O. Address Mansfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

41134 7
Do not use this space.

1. PLACE OF DEATH
(a) County Wright — Registration District No. 909
(b) Township — Primary Registration District No. 6220 — Registered No.
(c) City Pleasant Valley — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dorothy May Proek
(a) Residence, No. — St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) S

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

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

7. AGE — YEARS 1 — MONTHS 1 — DAYS 25 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED, 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 13, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
I last saw h.... alive on ....., 19.... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia Bronchial	

Other contributory causes of importance:
None -

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) L. L. Vannoy, M. D.
(Address) Norwood Mo

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.