

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

7147
Do not use this space.

1. PLACE OF DEATH
 (a) County Rapaudette Registration District No. 460
 (b) Township St. James Primary Registration District No. 3623
 (c) City or Higginsville (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 Wm. Proett
 (a) Residence, No. Rapaudette Co. Mo. Davis Lane (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 25, 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 11 27

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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) Sumner Mo

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

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

17. INFORMANT (ADDRESS) Lillian Proett Higginsville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Higginsville DATE 2-25-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Holzer & Muench Higginsville Mo

20. FILED Mar. 1 1940 Robt. Tiffany Webb Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 22 1940

22. I HEREBY CERTIFY, that I attended deceased from Oct 1939, to Feb 22 1940
 I last saw him alive on Feb 22 1940 Death is said to have occurred on the date stated above, at 7:30 m.
 The principal cause of death and related causes of importance were as follows:
Coronary Occlusion
Hypertension
 Date of onset _____

Other contributory causes of importance
Arteriosclerosis

Name of operation None Date of _____
 What test confirmed diagnosis? None Was there an autopsy? _____

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? _____
 (Signed) Lucas D. Moore M. D.
 (Address) Higginsville Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FORM 1 X18603

STATEMENT BY LICENSED EMBALMER

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3/5/40

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.....
Licensed Embalmer No.....
P. O. Address.....

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

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
State File No. 7147Registration District No. 460Primary Registration District No. 3623Registrar's No. 13

1. PLACE OF DEATH

 (a) County Lafayette
 (b) City or town Dover
 (c) Name of hospital or institution:
 (If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

 (d) Length of stay: In hospital or institution.....
 In this community..... (Specify whether
 years, months or days)
3. (a) PRINT FULL NAME Hy Proett

3. (b) If veteran, name war..... 3. (c) Social Security No.....

 4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

 8. AGE: Years 73 Months 11 Days 27 If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

 19. (a) Gene H. Co (b) Tiffany Webb
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

 (a) State Missouri (b) County Lafayette

(c) City or town..... (If outside city or town limits write "RURAL")

 (d) Street No. Amal-Dover Truss
 (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

 20. DATE OF DEATH Month Feb day 22
 year 1946 hour..... minute..... M.

 21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
 that I last saw him..... alive on....., 19.....,
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

 Other conditions.....
 (Include pregnancy within 3 months of death)

 Major findings:
 Of operations.....

Of autopsy.....

Duration

PHYSICIAN

 Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

 23. Signature Ernest W. Moore (M. D. or other)

 Address Higginsville Date signed mo

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTAL

S-7147