

No. 2
8-43
5-1089
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29037

FILED SEP 13 1944 369
Registration District No.

Primary Registration District No. 6250

Registrar's No.

1. PLACE OF DEATH:

(a) County Wayne

(b) City or town Rural Blackb Mass
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Wappapello Lake
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott 100

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

(d) Street No. 747 N. Ranney
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME ROGER DIXON PROCTOR

3. (b) If veteran, name war —

3. (c) Social Security No. 317-07-7235

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14
year 1944 hour 8 minute 45 P.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.

4. Sex Male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Margaret

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Dec 22 1898
(Month) (Day) (Year)

Immediate cause of death Accidental drowning

Duration _____

8. AGE: Years 45 Months 7 Days 21
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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

10. Usual occupation Dist. Black mgr for

11. Industry or business Allis Chalmers Imp Co.

12. Name Tom B. Proctor

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

14. Maiden name Anna Dixon

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

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

(c) Accident, suicide, or homicide (specify) accident !!!

(b) Date of occurrence 8-14-44

(c) Where did injury occur? Wappapello Lake, Wayne Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Wappapello Lake
(Specify type of place)

While at work? _____ (e) Means of injury _____

16. (a) Informant Mrs. Margaret Proctor

(b) Address Sikeston, Missouri

17. (a) Burial & removal (b) Date thereof 8-17-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Vernon Ind

18. (a) Signature of funeral director Welch Funeral Home

(b) Address Sikeston Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

23. Signature Dr. P. J. Lasker (M.D. or other) _____
Address Wappapello Lake Date signed 8-15-44

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

MOTHER FATHER

1222 (Licensed Embalmer's Statement on Reverse Side)

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

Raymond Crews

Licensed Embalmer No.

3467

P. O. Address

Sikeston Mo

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, fact should be so stated above.

Registration District No. 369

Primary Registration District No. 6250

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

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Rural Black River
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Wappapello Lake
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Roger W Proctor

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 on

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Dec-22-1923
(Month) (Day) (Year)

8. AGE: Years 45 Months 7 Days _____ If less than one day, _____ min.

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

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Sept 20, 1944 (b) Miss Lottie Manner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 15 Year 1944 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 _____

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 _____

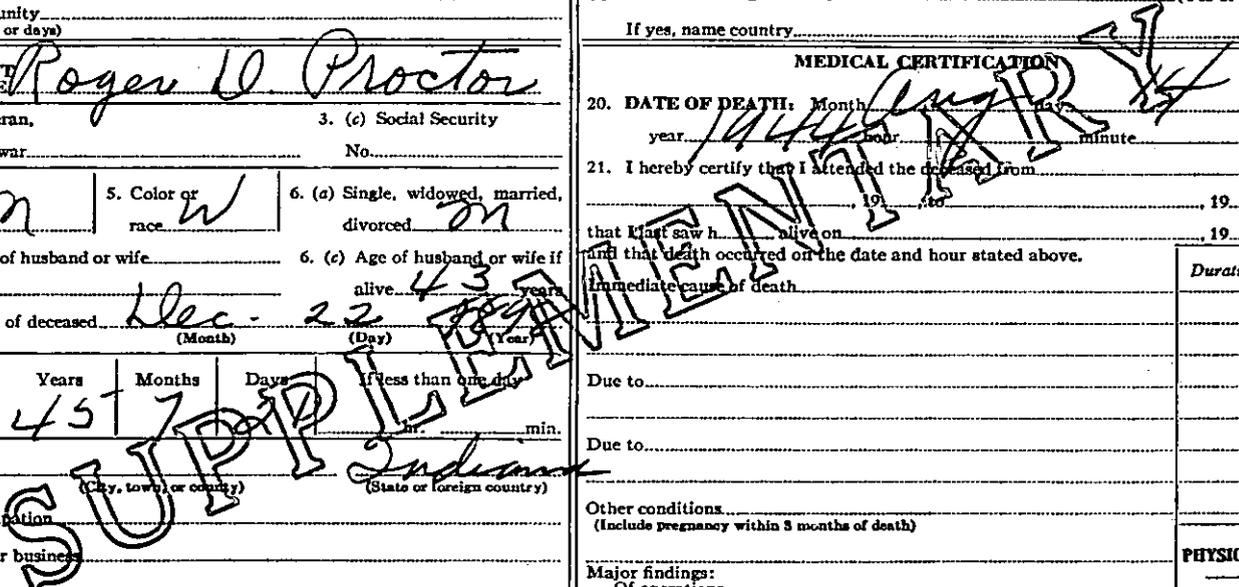
23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.



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