

FILED SEP 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

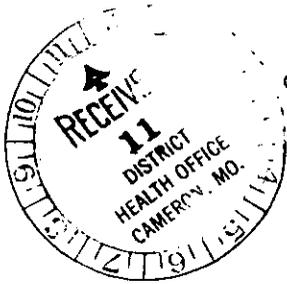
State File No. **30153**

BIRTH NO. _____ REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **4203** Registrar's No. **99**

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Grundy	
b. CITY (If outside corporate limits, write RURAL and give township) Galt		c. LENGTH OF STAY (In this place) Life	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) Galt	
		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) T c. (Last) PROCTOR			4. DATE OF DEATH (Month) (Day) (Year) 7-21-50
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec 3 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Hardware	9. AGE (In years last birthday) Months Days 73
11. BIRTHPLACE (State or foreign country) Grundy Co Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Frank Proctor		13b. MOTHER'S MAIDEN NAME Lucy Martin	14. NAME OF HUSBAND OR WIFE Grace Proctor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Grace Proctor
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 1-1-1949 , to 7-21-1950 that I last saw the deceased alive on 7-21-1950 and that death occurred at 10:00 a. m., from the causes and on the date stated above.			
23a. SIGNATURE H. C. Weston M.D.		23b. ADDRESS Galt, Mo.	23c. DATE SIGNED 7-22-50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-23-50	24c. NAME OF CEMETERY OR CREMATORY Galt Cemetery	24d. LOCATION (City, town, or county) (State) Galt Mo
DATE REC'D BY LOCAL REG. 7-23-50	REGISTRAR'S SIGNATURE Jane Fair	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PK Payne San Galt Mo	

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

0400



NOV 24 1953

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed P. R. Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.