

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6725**

FILED MAR 1 1955

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **542** Registrar's No. **280**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Ferguson)		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Ferguson
d. FULL NAME OF HOSPITAL OR INSTITUTION 227 Catherine		STREET ADDRESS (If rural, give location) 227 Catherine	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) F.	c. (Last) Proctor	4. DATE OF DEATH (Month) (Day) (Year) 2-1-55
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 15 1892	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 4 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Oran Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry Proctor	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Ruby Proctor.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year & dates of service) No	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT'S SIGNATURE OR NAME Ruby Proctor	ADDRESS 227 Catherine Ferguson Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate		
ANTECEDENT CAUSES		DUE TO (b)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **8-17**, 19**52**, to **2-1**, 19**55**, that I last saw the deceased alive on **2-1**, 19**55** and that death occurred at **8:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D. H. Proctor M.D.	23b. ADDRESS Ferguson Mo.	23c. DATE SIGNED 2-2-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-2-55	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Naylor Mo.
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DATE REC'D BY LOCAL REG. 2-2-55	REGISTRAR'S SIGNATURE Hubert R. Danks M.D.	25. FUNERAL DIRECTOR'S SIGNATURE A.H. Hoppe	ADDRESS 4704 Washington Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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

52

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.....
Signature of Student Embalmer

Signed *John J. Laine*
Licensed Embalmer No. *410*
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.-
If this body is not embalmed, fact should be so stated above.