

*Dr. Halcomb*

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**59-014328**

STATE FILE NUMBER

**FILED APR 29 1959**

Registration District No. *272*

Primary Registration District No. *3908*

Registrar's No. *26*

1. PLACE OF DEATH a. COUNTY <i>Dennis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Dennis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Steele</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Steele</i> 0780 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1</i>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lula</i> Middle <i>Maybelle</i> Last <i>Proctor</i>		4. DATE OF DEATH Month <i>4</i> Day <i>12</i> Year <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-11-1872</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home work</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Crockett Co Tenn</i>	9c. AGE (In years last birthday) Months <i>86</i> Days <i>10</i> Hours <i></i> Min. <i></i>
10a. FATHER'S NAME <i>Joseph Edwards</i>		10b. MOTHER'S MAIDEN NAME <i>Susan Norville</i>	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. NAME OF HUSBAND OR WIFE <i>Miss Edna Proctor</i>		Address <i>Steele Mo</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration</i> DUE TO (b) <i>Fiber</i> DUE TO (c) <i>Bilateral Bronchopneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>2 days</i> <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease Condition given in PART I (a) <i>491X</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>491X</i>	
20c. TIME OF INJURY Hour <i></i> Month, Day, Year <i></i> a.m. <i></i> p.m. <i></i>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Fall, 1957</i> to <i>4/11/59</i> and last saw <sup>her</sup> him alive on <i>4/11/59</i> Death occurred at <i>Steele</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Beile Halcomb, M.D.</i>		22b. ADDRESS <i>Steele, Mo</i>	
22c. DATE SIGNED <i>4/17/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4-14-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Roberson</i>	23d. LOCATION (City, town, or county) (State) <i>Bella Tenn</i>
24. FUNERAL DIRECTOR <i>Hermont Funeral Home Steele Mo</i>		25. DATE RECD. BY LOCAL REG. <i>4/20-59</i>	
ADDRESS <i>Steele Mo</i>		26. REGISTRAR'S SIGNATURE <i>J. St. James</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Noel E. Deane* .....

Licensed Embalmer No. *3941* .....

P. O. Address *Carrollton, Va.* .....

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.