

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006920

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 788

FILED FEB 26 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>JACKSON</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in lb <u>50 years</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3223 Prospect Avenue Hazelwood Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u></p> <p>c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>3223 HARRISON ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last <u>Beulah VICTORIA PROFFER</u></p>	
<p>4. DATE OF DEATH Month Day Year <u>FEBRUARY 4th 1963</u></p>	
<p>5. SEX <u>FEMALE</u></p>	<p>6. COLOR OR RACE <u>CAUCASIAN</u></p>
<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>1-22-88</u></p>
<p>9. AGE (last birthday) <u>75</u></p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARRIER</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>WYNER'S CAFETERIA BURFORDSVILLE, Mo.</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>JACOB F. PROFFER</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>MARY L. McCULLOUGH</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>NONE</u></p>	<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u></p>
<p>16. SOCIAL SECURITY NO. <u>[REDACTED]</u></p>	<p>17. INFORMANT <u>WILSON PROFFER 1105 SUNNY SLOPE DR. Address HICKMAN MILLS Mo.</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>Coronary Thrombosis</u> <u>Arterio-sclerosis</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arterio-sclerosis</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>	
<p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>April 58</u> to <u>2-4-63</u> and last saw her alive on <u>1-14-63</u></p> <p>Death occurred at <u>1040 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE <u>Ada B. Rader M.D.</u> (Degree or title)</p>	<p>22b. ADDRESS <u>18414 Locust Rt 31 Kansas City 45 Mo.</u></p>
<p>22c. DATE SIGNED <u>2.5.63</u> (State)</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u></p>	<p>23b. DATE <u>FEB. 5, 1963</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u></p>	<p>23d. LOCATION (City, town, or county) <u>JACKSON MISSOURI</u></p>
<p>24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS, KANSAS CITY Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>2-5-63</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>Ruth Long</u></p>	

VS 300 Rev. 4/59

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DATE AMENDED 4/5/63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF January 25, 1888

SHOULD READ January 23, 1888

ITEM NO. 8

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Informant

A. B. Rader

USE BLACK INK OR TYPEWRITER RIBBON

MISSOURI STATE BOARD OF HEALTH

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 James W. Larson

Licensed Embalmer No. 4889
P. O. Address Lathrop, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.