

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

**=63-016967**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 267 Primary Registration District No. 3048 Registrar's No. 2585 P3 STATE FILE NUMBER

**FILED APR 23 1963**

DO NOT WRITE ON THIS STUB AMENDED

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| VS 300<br>Rev. 4/59 | DATE AMENDED |
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY: <b>Nodaway</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE: <b>Mo.</b> b. COUNTY: <b>Nodaway</b>                                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: <b>Maryville</b>  |  | Length of stay in 1b.: <b>1 hour</b>   | c. CITY OR TOWN: <b>Pickering Rural</b>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: <b>St. Francis Hospital</b>   |  | Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location): <b>Union Twp.</b>   |
| 3. NAME OF DECEASED (Type or print)<br>First: <b>Everett</b> Middle: <b>Ray</b> Last: <b>PROCTOR</b>   |  | 4. DATE OF DEATH<br>Month: <b>April</b> Day: <b>13</b> Year: <b>1963</b>   |  |
| 5. SEX: <b>Male</b>  | 6. COLOR OR RACE: <b>White</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>                   | 8. DATE OF BIRTH: <b>3-30-1878</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY: <b>Farmer</b>   | 9. AGE (last birthday): <b>85</b>  |
| 11. BIRTHPLACE (City and state or country): <b>Linn County, Iowa</b>   |  | 12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME: <b>David L. Proctor</b>  |  | 13b. MOTHER'S MAIDEN NAME: <b>Mary Ann Hayzlett</b>  |  |
| 14. NAME OF HUSBAND OR WIFE: <b>Pearl Proctor</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): <b>no</b>  |  |
| 16. SOCIAL SECURITY NO.:   |  | 17. INFORMANT Address: <b>Mrs Pearl Proctor, Pickering, Mo.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain injury and hemorrhage</b><br>DUE TO (b) <b>Gunsnot wound (Self inflicted)</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |  | INTERVAL BETWEEN ONSET AND DEATH: <b>1 hour</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><b>Gunsnot wound entered through mouth and hit through vertex of head.</b> |  |
| 20c. TIME OF INJURY: Hour: _____ a.m. _____ p.m.   | 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 <b>April 13, 1963</b> to <b>April 13, 1963</b> and last saw him alive on <b>April 13, 1963</b> .<br>Death occurred at <b>8:55 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |  |  |
| 22a. SIGNATURE: <b>W.R. Jackson, M.D.</b> (Degree or title)  |  | 22b. ADDRESS: <b>Maryville, Mo.</b>  |  |
| 22c. DATE SIGNED: <b>4-17-63</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>   | 23b. DATE: <b>4-16-63</b>  | 23c. NAME OF CEMETERY OR CREMATORY: <b>Hopkins</b>   |  |
| 23d. LOCATION (City, town, or county): <b>Hopkins, Mo.</b>   |  | 23e. STATE: _____  |  |
| 24. FUNERAL DIRECTOR: <b>Stanley Swanson</b> ADDRESS: <b>Hopkins, Mo.</b>  |  | 25. DATE RECD. BY LOCAL REG.: <b>4-17-63</b>   |  |
| 26. REGISTRAR'S SIGNATURE: <b>Bern Bolt</b>  |  |  |  |

**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 Myself, Student Embalmer No. \_\_\_\_\_,  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Stanley Swanson*

Licensed Embalmer No. 3963

P. O. Address Hopkins, 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.

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