

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Richmond
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
County Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 years (Specify whether years, months or days) life (Specify whether years, months or days)

3: (a) PRINT FULL NAME William Alonzo Proffitt
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex MALE 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Maxine Janner Proffitt
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased: April 7 1862
(Month) (Day) (Year)

8. AGE: Years 86 Months 3 Days 14
If less than one day hr. _____ min. _____

9. Birthplace Ray County Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name William Proffitt

13. Birthplace Tennessee Tenn. 1
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Priest

15. Birthplace Kentucky 1
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Proffitt

(b) Address Richmond, Mo

17. (a) Burial (b) Date thereof July 23, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lepp's Chapel Cemetery

18. (a) Signature of funeral director Thomas J. Carter

(b) Address Richmond Mo

19. (a) July 24, 1948 (b) Mabel Jackson
(Date received local registrar) (Registrar's signature) 772

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ray 89
(c) City or town Richmond
(If outside city or town limits, write "RURAL") 5
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21
year 1948 hour 8 minute A.M.

21. I hereby certify that I attended the deceased from July 1 - 1948 to July 21 - 1948
that I last saw him alive on July 20 - 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to arterio Sclerosis

Due to Fractured Hip
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Fractured Hip
(b) Date of occurrence 20 Nov 48
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature E. G. Day (M, D, or other) MD
Address Richmond Date signed 7-23-48

MOTHER, FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed..... 8-12-48.....

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Thomas J. Carter*.....
Licensed Embalmer No. *4474*.....
P. O. Address..... *Richmond, 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 this body is not embalmed, fact should be so stated above.