No. 2
—2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 6 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

28559

State File No.

Registration District No. 282

Primary Registration District No. ~~3055~~ 5971

Registrar's No.

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Bolivar Rural Wm. [illegible]
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: [illegible]
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 2 weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 84

(c) City or town Bolivar Rural
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME William A. Dean

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased June (Month) 10 (Day) 1897 (Year)

8. AGE: Years 47 Months 2 Days 17 If less than one day hr. min.

9. Birthplace Polk Co. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William T. Dean
13. Birthplace Barton Co. (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Nettie B. Kelsey
15. Birthplace Unknown (City, town, or county) Unknown 4 (State or foreign country)

16. (a) Informant Marion Dean
(b) Address Humansville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 29, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Rondo Cemetery

18. (a) Signature of funeral director E. H. Primm
(b) Address Humansville, Mo.

19. (a) Aug 29 1944 (Date received local registrar) (b) Alice Palen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from Aug 1st, 1944, to Aug 22, 1944 that I last saw h. alive on Aug 22, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Probable cerebral hemorrhage

Due to arteriosclerosis —

Due to Enlarged heart nephritis dropsy

Other conditions following - pulling
(Include pregnancy within 3 months of death)
Fleeth - was very

Major findings:
Of operations Topic

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(b) Date of occurrence

(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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature Rosie C Nevins (M. D. or other) Mrd.

Address Humansville Mo Date signed 8-28-44

12 [illegible]

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7.
District File Number 8-44-980
Date Filed 9-5-44

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 by me Registered Apprentice No. working under my personal supervision.

Signed E H Primm

Licensed Embalmer No. 4282

P. O. Address Humansville, 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 this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X38930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Bolivar — Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 2 mk.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME William A. Dean

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased June (Month) 10 (Day) 1897 (Year)

8. AGE: Years 47 | Months 2 | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27
year 1944 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19.... to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Probable Cerebral hemorrhage
Arteria sclerosis & Enlarged heart
Due to Nephritis — dropsy following pulling of teeth was
Due to very toxic
acute due to toxins
Other conditions in System
(Include pregnancy within 3 months of death)

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy .....

130

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) .....
(b) Date of occurrence .....
(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?
..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

28559