

FILED DEC 8 1944

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Caulefield, Mo., Rural
(c) Name of hospital or institution: Bayer
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 3 1/2 yrs.
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Jimmie Lee 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 Widowed

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased 12/11-1940
(Month) (Day) (Year)

8. AGE: Years 3 Months 10 Days 20 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry of business

12. Name Mr. J. Dean

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

14. Maiden name Opiea Egleston

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

16. (a) Informant Mr. J. Dean

(b) Address Caulefield, Mo.

17. (a) (Burial, cremation, or removal) B. (b) Date thereof 10/26/44
(Month) (Day) (Year)

(c) Place: burial or cremation Waters Hill, Mo.

18. (a) Signature of funeral director Robertson
(b) Address West Plains, Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ozark 77
(c) City or town Caulefield
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 30
year 1944 hour 9 minute 30 A.M.

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

Immediate cause of death was run over by truck & crushed to death instantly

Due to 1944

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1944

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 077

(b) Date of occurrence 10-30-44

(c) Where did injury occur? Ozark Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Highway 80 near home

While at work? (Specify type of place) (e) Means of injury Truck crush

23. Signature CA Beach M.D. (M. D. or other) him
Address Caulefield, Mo. Date signed Oct 31

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

580

DR Beach

RECEIVED

District Health Officer No. 6,

District File Number 1244-1287

Date Filed DEC. 6 1944

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.....

S. D. Robertson

Licensed Embalmer No.....

3432

P. O. Address.....

New Haven

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. (262)

Primary Registration District No. 5887

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Rural, Bayou View
(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 _____
years, months or days

3. (a) PRINT FULL NAME

Jimmie Lee 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 Dec - 11
(Month) (Day) (Year)

8. AGE: Years 3 Months 10 Days 15 (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10530 (b) CA Beaul
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 31 Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

38482