

S. No. 2
 FORM-2-43
 Rev. 5-17-39
 I X35697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

1064
 83

FILED JAN 26 1945
 Registration District No. 149

Primary Registration District No. 1002

State File No. _____
 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 54 days
(Specify whether years, months or days)
 In this community 40 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson ⁴⁸
 (c) City or town Kansas City ³
(If outside city or town limits, write "RURAL")
 (d) Street No. 9th Central ⁸
(If rural, give location)
 (e) Citizen of foreign country? No ⁰ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John Dean
 (b) If veteran, name war No
 (c) Social Security No. 486-05-3771

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 6
 year 1945 hour 9 minute 30 A.M.

4. Sex M ⁰ 5. Color or race W
 6. (a) Single, widowed, married, divorced, MARRIED
 (b) Name of husband or wife Angeline Dean
 (c) Age of husband or wife if alive 60 years
 7. Birth date of deceased Feb 15 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 2 1945 to Jan. 6 1945
 that I last saw him alive on Jan. 6 1945
 and that death occurred on the date and hour stated above.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
| | <u>72</u> | <u>10</u> | <u>23</u> | hr. min. |

Immediate cause of death Cardiac decompensation with auricular fibrillation and pulmonary infarction with terminal bronchopneumonia

9. Birthplace Ill (City, town, or county) Ill (State or foreign country)
 10. Usual occupation employee Mead
 11. Industry or business Baron Fuel Co.
 12. Name UNKNOWN DEAN
 13. Birthplace Ill (City, town, or county) Ill (State or foreign country)
 14. Maiden name Ill
 15. Birthplace Ill (City, town, or county) Ill (State or foreign country)

Due to _____
 Due to _____
 Other conditions (Includes pregnancy within 3 months of death) 95 C
 Major findings: Of operations _____
 Of autopsy None

MOTHER FATHER
 16. (a) Informant Madeline Dean
 (b) Address 3805 Eastfield
 17. (a) Burial (b) Date thereof Jan 8 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation me morial Park
 18. (a) Signature of funeral director D. W. Neumann
 (b) Address 4018 Mead Creek
 19. (a) 1-8-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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?
 While at work? _____ (Specify type of place) _____ Means of injury _____
 23. Signature D. E. Usher (M. D. or other) MS.
 Address Med. Dir. Gen'l Hosp Date signed 1-6-45

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.