

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20694

State File No.

Registrar's No.

Primary Registration District No. 5635

V. S. No. 2
100M-9-43
Rev. 5-17-59
I X37823

DEPARTMENT OF HEALTH
By Act No. 1945

FILE OF DEATH:

1. County Madison
(b) City or town Phillipsburg
(c) Name of hospital or institution: Wagner
(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 yrs
years, months or days

3. (a) PRINT FULL NAME WILLIAM G. DEAN
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color of race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Elizabeth 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct - 8 - 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 29 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name unknown

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant Ralph Dean

(b) Address Springfield Mo

17. (a) Decease (b) Date thereof Dec 10 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prarie Grove

18. (a) Signature of funeral director R. B. Jones
(b) Address Buffalo Mo
19. (a) June 1 - 45 (b) Grace Raper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Dallas
(c) City or town Buffalo Mo
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7
year 1944 hour 1 minute 30 pm

21. I hereby certify that I attended the deceased from 5-7 1943 to 12-7 1944
that I last saw him alive on 12-7 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration _____

Due to Hypertensive heart disease

Due to _____

Other conditions Chronic valvular heart disease
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 830

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) (e) Means of injury _____

23. Signature Leonia H. Knowlton (M. D. or other) M.D.
Address Lebanon Mo Date signed 11/10/45

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

1090

(Licensed Embalmer's Statement on Reverse Side)

Received

Laclede County Health Unit

File No.

5-45-55

Date Filed

6/19/45

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.