. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26844

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 944

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2422 St Joseph Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community abt 45 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2422 St Joseph Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JASPER-M-DEAN
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mary E
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Sept (Month) 25 (Day) 1867 (Year)

8. AGE: Years 77 Months 11 Days 9 If less than one day hr. min.

9. Birthplace MC Lean (City, town, or county) Ill. (State or foreign country)
10. Usual occupation Ret Contractor
11. Industry or business
FATHER
12. Name James Dean
13. Birthplace (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name — Bodley
15. Birthplace (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Mrs. Lillian Smith
(b) Address 2422 St Joseph Ave.
17. (a) B (Burial, cremation, or removal) (b) Date thereof Sept 6 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Auburn Cem
18. (a) Signature of funeral director Stone Funeral Home
(b) Address St Joseph Mo
19. (a) Sept. 5, 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3rd year 1945 hour 3 minute A M.
21. I hereby certify that I attended the deceased from Jan 1st, 1945, to Sept 3rd, 1945 that I last saw him alive on Sept 2nd, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic nephritis	6 mo
Due to age	
Due to	
Other conditions Enlarged Prostate (Include pregnancy within 3 months of death)	?

Major findings:
Of operations
Of autopsy 131 B

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 Leroi Beck MD (M. D. or other)
Address Kmz Hill Bldg Date signed 9/3/45

1428 (Licensed Embalmer's Statement on Reverse Side)

Dr Beat.

DEC 1 1945

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 John Roy Stanney

Licensed Embalmer No. 2435

P. O. Address St Joseph

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.