

FILED SEP 12 1945

STANDARD CERTIFICATE OF DEATH

State File No. 27368

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 662

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

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Burge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)  
In this community 4 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 94  
(c) City or town Bolivar 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? no 1  
(Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Adrain Dean

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased July 10, 1900  
(Month) (Day) (Year)

8. AGE: Years 45 Months 1 Days 11 If less than one day hr. min.

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

10. Usual occupation Insurance Agent

11. Industry or business

12. Name Lewis Dean

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

14. Maiden name Elizabeth Manning

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

16. (a) Informant Martha Dean

(b) Address Bolivar, Mo.

17. (a) burial (b) Date thereof 8-21-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bolivar, Mo.

18. (a) Signature of funeral director Dutcherson Seapin

(b) Address Bolivar, Mo.

19. (a) 8-22-45 (b) W. W. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21  
year 1945 hour one minute 05 PM.

21. I hereby certify that I attended the deceased from July 1  
1945 to Aug 21 1945  
that I last saw him alive on Aug 21 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure  
Due to Symphatic leukemia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations UNK.  
Of autopsy UNK.

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 E. J. Hanon (M. D. or other) MD  
Address 1000 1/2 1st St Date signed 8-22-45

SEP 20 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.....

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.**

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