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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13829

FILED APR 24 1946

State File No. \_\_\_\_\_

Registration District No. 200

Primary Registration District No. 3-0-41-5720

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Rural Callao Mo. Co.  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon  
(c) City or town Callao  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM STEVENS 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 W 21

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

7. Birth date of deceased 9 (Month) 2 (Day) 1857 (Year)

8. AGE: Years 88 Months 6 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

12. Name JACOB DEAN

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

14. Maiden name CHARLOTTE SHACK

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

16. (a) Informant HENRY DEAN

(b) Address Callao, Mo.

17. (a) Removal (burial, cremation, or removal) Removal (b) Date thereof 3-26-46 (Month) (Day) (Year)

(c) Place: burial or cremation EADS CHAPEL RFD 24 CO.

18. (a) Signature of funeral director Fuel G. Thompson

(b) Address Madison Mo.

19. (a) 3/26/46 (Date received by Registrar) (b) Paul M. Neely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 26 year 1946 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 25, 1946 to March 26, 1946 that I last saw him alive on March 26, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 3 days

Due to Chronic nephritis ?

Due to Senile Deg. etc.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy 13/2

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 2

23. Signature P. D. Hester (M. D. or other) \_\_\_\_\_

Address Macon, Mo. Date signed 3/26/46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 4-46-842

Date Filed APR 22 1946

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 Fred A. Johnson

Licensed Embalmer No. 1470

P. O. Address Fred A. Johnson

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. May  
Registrar's No. x 90

Registration District No. 200 Primary Registration District No. 3-0-415720

**1. PLACE OF DEATH:**

(a) County Macou  
(b) City or town Callos Rural  
(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 William S 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 wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 2  
(Month) (Day) (Year)

8. AGE: Years 88 Months 6 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

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 \_\_\_\_\_

13. (c) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Luth Mcneely  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County (Macou)  
(c) City or town Callos (Rural)  
(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 May 26  
year 1986 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

13829

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