

FILED JUL 11 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20560

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 580

39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution O'Reilly VA Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
(Specify whether
in this community in this VAH years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Republic (Rural) 2
(If outside city or town limits, write "RURAL")
(d) Street No. Box 15, route 1 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME

Charles T. Dean

3. (b) If veteran, name war WW II

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Opal 6. (c) Age of husband or wife 23 years
7. Birth date of deceased January 12, 1917
(Month) (Day) (Year)

8. AGE: Years 30 Months 5 Days 17 If less than one day
hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name Thomas T. Dean
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Delphia Carter
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Correspondence Records
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 7/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 7-2-47 (b) W E Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29th
year 1947 hour Five minute 57 P. M.

21. I hereby certify that I attended the deceased from 12 May 1947 to June 29, 1947;
that I last saw him in alive on June 29, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Lymphosarcoma Duration _____

Due to _____
Due to _____

Other conditions 46 B
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Lymphosarcoma of retropharyngeal nodes + others
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 Paul [unclear] (M. D. or other) _____
Address VH H Springfield Mo Date signed 6/30/47

JAN 29 1948

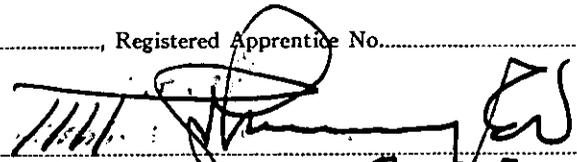
JUL 1 1947

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.

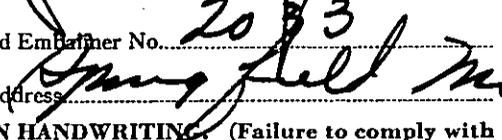
Signed



Licensed Embalmer No.

2083

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.