

FILED AUG 4 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25040

Registration District No. 280

Primary Registration District No. 4421

Registrar's No. 104

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

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Parkville Platte
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
16 W. 5th (at home)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 57 yrs.
years, months or days

3. (a) PRINT FULL NAME Howard Andrew Dean
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex male 5. Color or race white
6. (d) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 26, 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 2
If less than one day hr. min.

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

10. Usual occupation College Professor (Retired)

11. Industry or business none

MOTHER FATHER

12. Name James D. Dean
13. Birthplace Salem Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Agnes G. Burton
15. Birthplace Dodd Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Palmer
(b) Address 16 W. 5th St. Parkville, Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Parkville, Mo.

18. (a) Signature of funeral director L. H. Francis

(b) Address Parkville, Mo.

19. (a) July 1-47 (b) Mr. Ophelia R. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte 83
(c) City or town Parkville 0
(If outside city or town limits, write "RURAL")
(d) Street No. 16 W. 5th St. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th
year 1947 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 9th 1947, to June 28 1947, that I last saw him alive on June 21 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____
June 20, 1947 at 3 P.M.
Did not regain consciousness
Due to Cerebral hemorrhage 7/9/39
and repeated strokes +
Due to Epileptic seizures
Peter's grand
Other conditions (above)
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy no 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 2

23. Signature Dr. Victoria A. Harrison (M.D. or other) D.O.
Address 414 Bryant Bldg. K. C., Mo. Date signed 6/28/47

DISTRICT HEALTH OFFICE
Camden, Mo.

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, (Signature)
....., Registered Apprentice No.
working under my personal supervision.

Signed L. H. Francis
Licensed Embalmer No. 3451
P. O. Address Parkville Mo

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.