

FILED JAN 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5721

BIRTH NO. _____ REG. DIST. NO. 61 PRIMARY REG. DIST. NO. 4107 Registrar's No. 5

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| 1. PLACE OF DEATH a. COUNTY CEDAR | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cedar | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Eldorado Springs 34rd. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Eldorado Springs, Mo. 1 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Home 1 | | d. STREET ADDRESS (If rural, give location) 705 Joe Davis St. 0 | |

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|---|------------|-------------|-----------|---|
| 3. NAME OF DECEASED (Type or Print) DELBERT E. DEAN | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) 1-19-49 |
|---|------------|-------------|-----------|---|

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|-------------|------------------------|--|--------------------------------|------------------------------------|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married | 8. DATE OF BIRTH Aug. 27, 1877 | 9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours | IF UNDER 1 HRS. Min. |
|-------------|------------------------|--|--------------------------------|------------------------------------|------------------------|----------------------|-----------------------|----------------------|

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|--|-----------------------------------|--|-------------------------------------|
| 10a. USUAL OCCUPATION (Gives kind of work done during most of working life, even if retired) retired | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Illinois 1 | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|-----------------------------------|--|-------------------------------------|

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|---------------------------------|--|--|
| 13a. FATHER'S NAME Hillary Dean | 13b. MOTHER'S MAIDEN NAME Ida Loveland | 14. NAME OF HUSBAND OR WIFE Lulu B. Dean |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lulu B. Dean, 705 E. Joe Davis |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH Two months |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Possible Chronic Bronchial DUE TO (c) Asthma | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

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|------------------------|---------------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 4-20 | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
|------------------------|---------------------------------------|--|

| | | |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| | | |
|--|--|---------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? None |
|--|--|---------------------------------|

22. I hereby certify that I attended the deceased from Dec 27, 1948, to Jan 15, 1949, that I last saw the deceased alive on Jan 15, 1949, and that death occurred at 2:40 a.m., from the causes and on the date stated above.

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|---|-------------------------|--------------------------|
| 23a. SIGNATURE (Degree or title) J.W. Richardson M.D. | 23b. ADDRESS Piffins Mo | 23c. DATE SIGNED 1-19-49 |
|---|-------------------------|--------------------------|

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|---|------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE Jan 19, 1949 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Hope | 24d. LOCATION (City, town, or county) (State) Habersham Kansas |
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|----------------------------------|---|---|
| DATE REC'D BY LOCAL REG. 1-19-49 | REGISTRAR'S SIGNATURE J. W. Richardson Deputy | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edwin Carothers Eldorado Springs |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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1
0

RECEIVED
District Health Officer No. 7
District File Number 12-48-1636
Date Filed 1-24-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Floyd E. Carothers
Licensed Embalmer No. 4419

P. O. Address Edwards Springs

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.