

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

13291

File No. _____
Registered No. _____
St. _____ Ward)

1. PLACE OF DEATH

67 County Mississippi Registration District No. 569
Township _____ Primary Registration District No. 3763
City Wyatt (No. _____)

2. FULL NAME

James Olliver Dean

(a) Residence. No. Wyatt, Mo. St., _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. _____ da. How long in U. S., if of foreign birth? yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18, 1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ or _____ min.
4 3 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Wyatt Miss Co.
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Joe Dean
11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Point Miss.
(STATE OR COUNTRY) 2
12. MAIDEN NAME OF MOTHER Lucia Harris
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) West Point
(STATE OR COUNTRY) Miss.

14. INFORMANT Joe Dean
(Address) Wyatt Mo.

15. FILED 4/30, 1932 J. Marshall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/30 1932 4 A.M.

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 4 1/2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
had no physician from history of case had whooping cough

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) yrs. _____ mos. _____ da.

IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS none
(Signed) W. Marshall M. D.

, 19____ (Address) Wyatt Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

Rush Ridge 5/1 32

20. UNDERTAKER L. H. C. Blair ADDRESS Charleston Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY.

MAY 26 1932

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