

V. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

39690

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 11512

FILED JAN 3 1944

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: LITTLE SISTERS POOR 3225 N. Florissant  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 YEARS 8 MO  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JAMES VITAL DEAN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased FEB. 6, 1869  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 10 15 hr. min.

9. Birthplace DONT KNOW MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED LABORER

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

MOTHER FATHER

12. Name PETER DEAN

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

14. Maiden name MARY ANNE DUVAL

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

16. (a) Informant SISTER JEANNE

(b) Address 3225 N. FLORISSANT AVE.

17. (a) BURIAL (b) Date thereof 1-22-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) DEC 22 1943 (b) Registrar's signature J. F. Bredon  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 000  
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")  
(d) Street No. 3225 N. FLORISSANT AVE.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 21  
year 1943 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 9, 1943 to December 21, 1943  
that I last saw him alive on December 20, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 3?  
Due to 9 3

Other conditions Acute upper respiratory infection 5 days  
(Include pregnancy within 3 months of death)

Major findings: Of operations None  
Of autopsy None

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature Bernard H. Flosser (M.D. or other)  
Address 2301 Salubrious St Date signed 12-21-43

---

---

**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 William Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

**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.**