

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 20 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39415
Registrar's No. 3303

Registration District No. 359

Primary Registration District No. 4525

1. PLACE OF DEATH:

(a) County Vermon
(b) City or town Miles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 65 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vermon
(c) City or town Miles
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Henry Dees

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) ~~Single~~, ~~widow~~, married, divorced 1

6. (b) Name of husband or wife Ada Dees

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased October 23, 1873
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 12
If less than one day hr. _____ min. _____

9. Birthplace Hoboken, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Marshall Dees

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

14. Maiden name Josephine Burk

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

16. (a) Informant Charley R. Dees
(b) Address Manhattan Park

17. (a) Burial (b) Date thereof Nov 9 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miles Cemetery

18. (a) Signature of funeral director Henry Thomas
(b) Address Vermon, Missouri

19. (a) Nov 12 1946 (b) Mrs Ruth Faith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 4
year 1946 hour _____ minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 1944 to Nov 4, 1946
that I last saw him alive on Nov 3, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration sudden

Due to High blood pressure 2 yrs.

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: 878
Of operations _____
Of 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 _____

23. Signature C. L. Keithly (M. D. or _____)
Address _____ Date signed 11-6-46

330

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

10-26-2024
11-18-26

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 MS
....., Registered Apprentice No.
working under my personal supervision.

Signed L. B. Jones
Licensed Embalmer No. 1760
P. O. Address Nevada 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.