

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**8344**

State File No. ....

BIRTH NO. FILED **MAR 17 1954** REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **3021** Registrar's No. **33**

1. PLACE OF DEATH a. COUNTY <b>GRUNDY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY <b>MERCER</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>TRENTON</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>COLLERS HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>MEDISON TOWNSHIP</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>FOREST</b> b. (Middle) <b>PERRY</b> c. (Last) <b>DEAN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>FEB 19 1954</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV 26 1905</b>	9. AGE (In years last birthday) <b>48</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MO.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>WILLIAM DEAN</b>	13b. MOTHER'S MAIDEN NAME <b>STELLA BOYLE</b>	14. NAME OF HUSBAND OR WIFE <b>EDITH DEAN</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>EDITH DEAN Spickard MO.</b>

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute myocardial failure.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cardio-vascular - Renal decompensation</b>		
	DUE TO (c) <b>mitral regurgitation Diabetes mellitus</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		10 years. <b>3 years.</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4/2X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-2, 1954**, to **2-19, 1954**, that I last saw the deceased alive on **2-18, 1954**, and that death occurred at **12:55 AM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>E. L. Blank, M.D.</b>	23b. ADDRESS <b>Trenton, MO.</b>	23c. DATE SIGNED <b>2/20/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>FEB-21-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>HALF ROCK CEM</b>
24d. LOCATION (City, town, or county) (State): <b>HALF ROCK MO.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>SCHOOLER FUNERAL HOME Spickard MO.</b>
DATE REC'D BY LOCAL REG. <b>2-21-1954</b>	REGISTRAR'S SIGNATURE <b>Jane Jairo</b>	

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

No. 300  
10.48

402  
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**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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard 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.