

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017597  
STATE FILE NUMBER

Health,  
& Welfare  
Public  
Service

S. 300  
1-57

0020

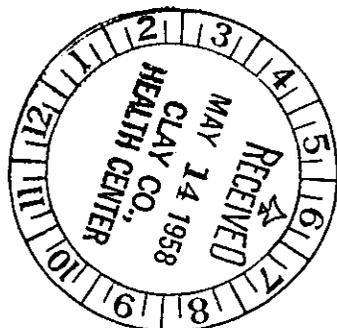
FILED MAY 19 1958 Registration District No. 21 Primary Registration District No. 3012 Registrar's No. H1

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits give TOWNSHIP only) <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Norborne</u> 0170 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Hosp. 8 Mos.</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSCOE N DEAN</u>			4. DATE OF DEATH Month Day Year <u>May 5 1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1870</u>
9. AGE (In years less birthday) <u>88</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	11. BIRTHPLACE (City and state or country) <u>Carroll Co. Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Dr. C. B. Dean</u>	
13b. MOTHER'S MARDEN NAME <u>Alpha Boyer</u>		14. NAME OF HUSBAND OR WIFE <u>Maudie E Dean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>488-38-6469</u>	17. INFORMANT Address <u>Marquess Dean, Norborne Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterial sclerotic heart disease class II</u>			<u>10 yr S.</u>
DUE TO (c) <u>arteriosclerosis</u> — <u>4200</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Renal arterial sclerosis with anuria.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>5-4-58</u> to <u>5-5-58</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>5-5-58</u> Death occurred at <u>8:15 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Doris Murgan M.D. O</u>		22b. ADDRESS <u>Excelsior Springs, Mo</u>	22c. DATE SIGNED <u>5-6-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5-7-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Carrollton Mo.</u>
24. FUNERAL DIRECTOR <u>Stanley &amp; Gibson, Carrollton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5-5-58</u>	26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



MAY 23 1950

### 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 .....  
Signature of Student Embalmer

Signed Ben W. Gibson

Licensed Embalmer No. 2961  
P. O. Address Carrollton

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.