S. No. 2
M—5-42
5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 28 1945

Registration District No. 1

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3000

State File No. 8883

Registrar's No.

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Grim-Smith Hospital & Clinic 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 19 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Macon
(c) City or town Rural 65
(If outside city or town limits, write "RURAL")
(d) Street No. Tyler Township 0
(If rural, give location)
(e) Citizen of foreign country? No 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Katherine Fay Deacon
3. (b) If veteran, name war —
3. (c) Social Security No.

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 18 (Day) 1925 (Year)

8. AGE: Years 19 Months 4 Days 3 If less than one day hr. min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)
10. Usual occupation Clerk in Store
11. Industry or business Butler Bros St. Louis Mo
FATHER
12. Name Murrel Deacon
13. Birthplace Mo (City, town, or county) 0 (State or foreign country)
MOTHER
14. Maiden name Nettie Power
15. Birthplace Mo (City, town, or county) 0 (State or foreign country)
16. (a) Informant Murrel Deacon
(b) Address Atlanta Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar (Month) 23 (Day) 1945 (Year)
(c) Place: burial or cremation La Plata Mo
18. (a) Signature of funeral director D. S. Christie
(b) Address La Plata Mo
19. (a) Mar 23-45 (Date received local registrar) (b) H. M. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21
year 1945 hour 12 minute 50 P M.
21. I hereby certify that I attended the deceased from March 17, 1945, to March 21, 1945
that I last saw her alive on March 21, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death — Acute yellow atrophy of liver	1 wk
Due to Septicemia (?)	10 days
Due to	
Other conditions — (Include pregnancy within 3 months of death)	

Major findings:
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? 0 (Specify type of place)
While at work? (e) Means of injury

23. Signature George E. Grim 0 (M. D. or other) MD
Address Kirksville, Mo Date signed 3-21-45

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 1
District File Number B-15-55
Date Filed MAR 26 1945

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 D. S. Gheritie

Licensed Embalmer No. 1109

P. O. Address La Plata Md

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 1 Primary Registration District No. 10493000 Registrar's No.

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Grim Smith Hospital & Clinic (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Rural Lyda Twp (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Katherine F Deacon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov 8 (Month) (Day) 1925 (Year)

8. AGE: Years 19 Months 4 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

8883