

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

State File No. **26953**

No. 300
10-48

FILED AUG 29 1955

BIRTH NO. _____		REG. DIST. NO. <u>201</u>		PRIMARY REG. DIST. NO. <u>5736</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>				
b. CITY OR TOWN <u>Atlanta, Ga</u>		c. LENGTH OF STAY (in this place) <u>16 yrs</u>		c. CITY OR TOWN <u>Atlanta</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Died at Home</u>				e. STREET ADDRESS (If rural, give location) <u>R.F.D. #3</u> 0610				
3. NAME OF DECEASED (Type of Print) a. (First) <u>Marcel</u> b. (Middle) <u>Deacon</u> c. (Last) <u>Deacon</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 10 - 1955</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 20 1903</u>		
9. AGE (In years last birthday) <u>52</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Macon Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farm Work</u>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME <u>Jacob W Deacon</u>			13b. MOTHER'S MAIDEN NAME <u>Elaine Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Hettie K. Deacon</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>497078848</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hettie K Deacon</u> ADDRESS <u>Atlanta Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Stomach</u> ANTECEDENT CAUSES DUE TO (b) <u>Generalized Ca of</u> DUE TO (c) <u>Lines of Surg.</u> II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <u>3 mo 2 wk</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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 <u>June 12, 1955</u> to <u>Aug 10, 1955</u> , that I last saw the deceased alive on <u>Aug 10, 1955</u> and that death occurred at <u>10:45 p.m.</u> from the causes and on the date stated above.								
23a. SIGNATURE <u>W. L. ...</u> (Degree or title)				23b. ADDRESS <u>Atlanta Mo</u>		23c. DATE SIGNED <u>8-12-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Aug 12, 55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LaPlata Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>LaPlata Mo</u>		
DATE REC'D BY LOCAL REG. <u>Aug 16 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs O B ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Goodding</u> ADDRESS <u>Atlanta Mo</u>				

(Licensed Undertaker's Statement on Reverse Side)

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

55

RECORDED 8.23.55
MAR 20 1956
DEKALB COUNTY HEALTH DEPARTMENT
County File No. 855.143
Date Filed 8.26.55

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, by, Student Embalmer No.

working under my personal supervision..

Student
Signature of Student Embalmer

Signed *H. M. Gooding*

Licensed Embalmer No. 1750

P. O. Address Atlanta

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.