

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 3 0 1959

'59 0 4 5 3 6 4

211058

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Brentwood (17)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) 9785 Litzsinger Rd.	

3. NAME OF DECEASED (Type or print) First William Middle Thomas Last Deacon	4. DATE OF DEATH Month November Day 29 Year 1959
-----------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------

5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1897	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
--------------------	-------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------	----------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. of Solvents and Plastics Company	10b. KIND OF BUSINESS OR INDUSTRY Webster Groves Mo.	11. BIRTHPLACE (City and state or country) U.S.A.	12. CITIZEN OF WHAT COUNTRY
-------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------	----------------------------------------------------------	-----------------------------

13a. FATHER'S NAME Andrew T. Deacon	13b. MOTHER'S MAIDEN NAME Emma Dierking	14. NAME OF HUSBAND OR WIFE Virginia B. Deacon
--------------------------------------------	------------------------------------------------	-------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.I.	16. SOCIAL SECURITY NO. yes	17. INFORMANT Mrs. Virginia B. Deacon 9785 Litzsinger Rd
----------------------------------------------------------------------------------------------------------------------------	------------------------------------	-----------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis	INTERVAL BETWEEN ONSET AND DEATH 1 minute
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) atherosclerosis	
DUE TO (c) 420.1	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
-----------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 WORK <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 **10/2/56** to **death** and last saw her/him alive on **11/28/59**
Death occurred at **11/29/59** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert James M.D. (Degree or title)	22b. ADDRESS 3720 Washington	22c. DATE SIGNED 11/30/59
-----------------------------------------------------------	-------------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Dec. 1, 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) St. Louis County Missouri.
------------------------------------------------------------	-------------------------------	---------------------------------------------------------------	---------------------------------------------------------------------------------

24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar Bly'd. ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 30 1959	26. REGISTRAR'S SIGNATURE Robert Smith, M.D.
-----------------------------------------------------------------------------	-------------------------------------------------	-----------------------------------------------------

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 27 1960

Mr. Wm. Deason

FEB 19 1960

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 Arnold W. Schoen

Licensed Embalmer No. 3864

Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.