

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

38823

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **Baptist Hospital**)..... St. (Ward)

File No.
Registered No. **11254**
St. (Ward)

2. FULL NAME

(a) Residence, No. **3123 Eads Ave** St. **17** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Nellie B. Deeds**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 10-1860**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 **4** **6**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Merchant**
(b) General nature of industry, business, or establishment in which employed (or employer) **Automobile**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ills**

10. NAME OF FATHER **David Deeds**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Penn**

12. MAIDEN NAME OF MOTHER **Mary A. Bird**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Penn**

14. INFORMANT **Mary E. Robinson** (Address) **3123 Eads Ave**

15. FILED **37** 1929 **Max C. Starkeff** REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 16** 1929

17. I HEREBY CERTIFY, That I attended deceased from **July 31**, 19**29**, to **Nov 16**, 19**29**, that I last saw him alive on **Nov 15**, 19**29**, and that death occurred, on the date stated above, at **7:15 A. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pernicious Anemia
7 1/2
1 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Stroke from est of tooth followed by infection of mouth** (duration) yrs. **1** mos. **7** ds.

18. WHERE WAS DISEASE CONTRAICTED IF NOT AT PLACE OF DEATH? **580**

8 DID AN OPERATION PRECEDE DEATH? DATE OF WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS (Signed) **O. C. Raines**, M. D. **11/18, 1929** (Address) **370 Meno Bldg**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Valhalla** DATE OF BURIAL **Nov 19** 19**29**

20. UNDERTAKER **Element and Leo Strand Blvd** ADDRESS **2217**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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