

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

Do not use this space.

6913

1. PLACE OF DEATH

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

2. FULL NAME

(a) Residence. No. **2030 Ann Ave** Ward **St Louis 23**
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **20** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF H = A. Bearden		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 - 1880		
7. AGE	YEARS 50	MONTHS 9
	DAY 19	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Housewife (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

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

PARENTS	10. NAME OF FATHER Samuel B. Reed
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri
	12. MAIDEN NAME OF MOTHER Dehlin Kirkland
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT **H = A. Bearden**
 (Address) **2030 Ann Ave**

15. FILED **19 1930** **Mar C Starkey**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2 - 19 - 1930**
 17. I HEREBY CERTIFY, That I attended deceased from **Feb 14**, 19**30**, to **Feb 19**, 19**30**, that I last saw her alive on **Feb 17**, 19**30**, and that death occurred, on the date stated above, at **9⁰⁰ a.m.**

18. THE CAUSE OF DEATH* WAS AS FOLLOWS: **68 Addison's Disease**
 (duration) **Rev** yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) **Malnutrition**
 (duration) yrs. mos. ds. **Sub**

18. WHERE WAS DISEASE CONTRACTED **63**
 IF NOT AT PLACE OF DEATH
 19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF
 WAS THERE AN AUTOPSY? **no**
 WHAT TEST CONFIRMED DIAGNOSIS? **Lab**
 (Signed) **L. Bearden**, M. D.

Feb **19**, 19**30** (Address) **Mo. Pac. Hosp**
 *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 **Piedmont Mo** DATE OF BURIAL **2 - 21 19 30**

20. UNDERTAKER **Dr C Maydell** ADDRESS **1926 Allen**

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.

WHITE PLAIN, WITH UNPAID INK—THIS IS A PERMANENT RECORD

235
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