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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31810**
Registrar's No. **8770**

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether _____)

In this community _____
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3517 Lucas Ave
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME BEVERLY DEEMS

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: About 83
(Month) (Day) (Year)

8. AGE: abt 83 Years Months Days If less than one day
hr. min.

9. Birthplace: Beverly West Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Printing Business

MOTHER FATHER { 12. Name Jeramin Deems

13. Birthplace Wood Co. W Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Kate Celestine

15. Birthplace Little Rock Ark
(City, town, or county) (State or foreign country)

16. (a) Informant Masonic Board of Relief

(b) Address 3872 Hartford St - 4941 Eisking St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/45
(Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Road

19. (a) OCT 11 1945 (Date received local registrar)

J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10th
year 1945 hour 9:45 minute A .M.

21. I hereby certify that I attended the deceased from 10/2/45
19____ to 10/10/45 19____
that I last saw her alive on 10/10/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: arteriosclerotic heart disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

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? _____

23. Signature Herbert C. Fitt (M. D. or other)

Address 1515 Lafayette St signed 10/10/45

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 Arnold W. Schoene

Licensed Embalmer No. 2864

P. O. 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 this body is not embalmed, fact should be so stated above.