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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 20227

Township ..... Primary Registration District No. 1003 Registered No. 6019

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME Chris Parashkeff

(a) Residence. No. West Maryland Hotel 19 Ward. (If nonresident give city or town and State)

(Usual place of abode) 4496 West Maryland

Length of residence in city or town where death occurred 9 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): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 23 - 1877

7. AGE: Years 50 | Months | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hmsuman

(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) Bulgaria

PARENTS

10. NAME OF FATHER Mike Parashkeff

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

12. MAIDEN NAME OF MOTHER Anna Unknown

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

14. INFORMANT Hospital Information E Kirkman

(Address) City Hospital

15. FILED JAN 30 1927 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 1927

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1927, to June 21, 1927, that I last saw him alive on June 21, 1927, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of pancreas

46 F

49

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Edmund R Sheridan, M.D.

6/21, 1927 (Address) City Hospital

*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: Calvary Cemetery

DATE OF BURIAL: July 1 1927

20. UNDERTAKER: J. H. Gibken L. & U. Co. 2842

ADDRESS: Miramar

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.

PERMANENT RECORD

Pasashkiff