

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

Do not use this space.

28378

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No.)

File No. **17897**

Registered No.

St. Ward)

2. FULL NAME

Maria Kekelis

(a) Residence. No. *2723 Bacon St.* *11* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec. 26, 1926*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>8</i>	<i>9</i>		

8. OCCUPATION OF DECEASED

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

Child

(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

10. NAME OF FATHER

John Kekelis

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

Greece

12. MAIDEN NAME OF MOTHER

Penelope Orphan

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

Greece

14. INFORMANT *George Orphan*
(Address) *4627 No. Sarah St.*

15. FILED *SEP - 6 1927*
Max C. Starckoff
REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 5th 1927*

17. I HEREBY CERTIFY That I attended deceased from *Aug 31st* 19*27* to *Sept 5th* 19*27* (that I last saw him alive on *Sept 5th* 19*27* and that death occurred, on the date stated above, at *5:30 a.m.*)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pituitary Tumor Pressured
Brain

CONTRIBUTORY (SECONDARY) *108*
(duration) yrs. mos. da. *8 da.*

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Ernest J. ... M. D.*
, 19 (Address) *211 Tenth St.*

*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 *St. Matthews* **DATE OF BURIAL** *9-6-1927*

20. UNDERTAKER *L. Spelbrink* **ADDRESS** *1321 Franklin*

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.

