

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

23453  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**

(b) Township ..... Primary Registration District No. **1003**

(c) City **St. Louis** (d) Street No. **5036a Enright** St. **12**  
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred **28** yrs. mos. ds. (f) How long in U.S., if of foreign birth **28** yrs. mos. ds.

2. PRINT FULL NAME **John G. Alexandres** **425**

(a) Residence, No. **5036a Enright** St. **12** (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Male**

4. COLOR OR RACE **White**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan 14, 1885**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

**53**      **5**      **24**

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Cook**

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) **June 1938**

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Greece**

FATHER

13. NAME **George Alexandres**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Greece**

MOTHER

15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Greece**

17. INFORMANT **George Alexandres**  
(ADDRESS) **5036a Enright**

18. BURIAL, CREMATION, OR REMOVAL  
PLACE **St. Matthews Cemetery** DATE **7-11-38**

19. FUNERAL DIRECTOR (NAME) **Albert H. Hoppe Inc.**  
(ADDRESS) **429 North Euclid Ave.**

20. FILED **JUL 10 1938** **J. D. Bredich**  
Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-8**, 19**38**

22. I HEREBY CERTIFY, That I attended deceased from **Nov 1937**, 19**38**, to **July 8**, 19**38**

I last saw him alive on **July 8**, 19**38**. Death is said to have occurred on the date stated above, at **9:15 p.m.**

The principal cause of death and related causes of importance were as follows:

**Myocardial failure**  
**Chloroform anesthesia**

Date of onset **5-8-38**  
**5-6-38**

**131**

Other contributory causes of importance:  
**arteritis (athermatous) Jan 1937**

Name of operation **None** Date of **None**

What test confirmed diagnosis? **Ray Lab** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify **None**

(Signed) **J. D. Bredich**, M. D.  
(Address) **700 N. Main Highway**

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.

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

I X14028

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**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.....

*J. G. Sullivan*

Licensed Embalmer No. 1122

P. O. Address.....

**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, above space should be left blank.**