

REC'D AUG 8 1938

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

**24141**  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 2646  
 (c) City Kansas City (d) Street No. 3319 Gillham Road St.  
 (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Sophia John Vassiliades

(a) Residence, No. 3319 Gillham Road St.  (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 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 Rev. John Vassiliades

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 28, 1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
40 0 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. At home  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

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

FATHER 13. NAME J. Vassiliades

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

MOTHER 15. MAIDEN NAME Astales

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

17. INFORMANT Rev. John Vassiliades  
 (ADDRESS) 3319 Gillham Road, Kansas Cy., Mo

18. BURIAL, CREMATION, OR REMOVAL K.C. Mo  
 PLACE Floral Hills DATE 7-4 1938

19. FUNERAL DIRECTOR (NAME) Stine & McClure  
 (ADDRESS) Kansas City, Missouri.

20. FILED July 2, 1938 M. M. Crowe, reg.  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 1, 1938

22. I HEREBY CERTIFY, That I attended deceased from

1/4, 1938 to 6/30, 1938  
 I last saw him alive on 6/30, 1938 Death is said to have occurred on the date stated above, at A. m. 12:30

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

Retinoblastoma  
Sarcinoma

Date of onset about 2 1/2 yrs ago

Other contributory causes of importance:

Name of operation Autopsy Date of July 1938

What test confirmed diagnosis? Biopsy Was there an autopsy? Yes

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? Yes

If so, specify \_\_\_\_\_

(Signed) Robert G. [Signature]

(Address) 20 Professional Bldg

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STATE OF  
NEW YORK  
DEPARTMENT OF HEALTH

*Frank P.*

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

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CERTIFICATE OF DEATH**

Do not use this space.

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**1. PLACE OF DEATH**

County Jackson  
Township K.C.  
City K.C.

Registration District No. 399-  
Primary Registration District No. 1002-

File No. 24141  
Registered No. 2646-  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Sophia J. Vasiliades

(a) Residence, No. 3319 Millham Rd. 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
40 - 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19\_\_

19. UNDERTAKER (ADDRESS)

FILED July 2, 1938 M.M. Browne Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 1, 1938

22. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Reticular endotheliosis  
Parcoma -  
(Mediastinal)  
Date of onset: 2 1/2 yrs

Other contributory causes of importance:  
Hysterectomy 7-35

Name of operation: \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) Robert M. Clunham, D.  
(Address) 820 Prof. Bldg.

