

REC'D FEB 10 1939

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

791
1003

434

Do not use this space.

434

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No.....
(c) City St. Louis, Missouri (d) Street No. City Sanitarium St.
(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? yrs. mos. ds.

2. PRINT FULL NAME George Lillios

(a) Residence, No. 1826 Lafayette St. 23
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-23-1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 8 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Shoe Worker
9. Industry or business in which work was done, as saw mill, bank, etc. Shoe Mfg.
10. Date deceased last worked at this occupation (month and year) 1935 11. Total time (years) spent in this occupation

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

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) John B. Varner, M.D. 5400 Arsenal St

18. BURIAL, CREMATION, OR REMOVAL PLACE S. MATTHEWS Cem. DATE 1-14-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe, Inc. 4700 Washington Blvd.

20. JAN 13 1939 J. B. Biduch Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-12-39 19

22. I HEREBY CERTIFY, That I attended deceased from 7-1-38, 19, to 1-12-39, 19. I last saw him alive on 1-12-39, 19. Death is said to have occurred on the date stated above, at 3:15 A.M.
The principal cause of death and related causes of importance were as follows:

General Paresis of the Insane (onset 7-1-38x)
85

Other contributory causes of importance:
Malnutrition Asthenia 7-1-38x

Name of operation..... Date of.....
What test confirmed diagnosis?..... 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?.....
If so, specify John B. Varner, M. D.
(Signed) City San.
(Address)

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 *Albert G. Kofke*

Licensed Embalmer No. *2971*

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.