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.

DEC'D MAY 10 1939

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

12786
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. City Hospital No. 1 St. Registered No. 3128
(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.

D. 15005

2. PRINT FULL NAME 316 Steve Stavrianopulos
(a) Residence, No. 1501 Market St. 25
(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
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 10, 1879
7. AGE 59 YEARS MONTHS 3 DAYS 21 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Bartender
9. Industry or business in which work was done, as saw mill, bank, etc. nil
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 ANDREW STAVRIANOPULOS
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greece

MOTHER
15. MAIDEN NAME STATHANIS PANASOPULOS
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greece

17. INFORMANT (ADDRESS) Hosp. Info M. Kent
18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Matthews Cemetery DATE April 4, 1939
19. FUNERAL DIRECTOR (NAME) Mullen Bros
(ADDRESS) 4259 Lindell Bulvd
20. FILED APR 3 1939 J. F. Budrick Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/1/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 1/14/39, 19 to 4/1/39, 19
I last saw him alive on 4/1/39, 19 Death is said to have occurred on the date stated above, at 5.15 a.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Carcinoma of Right Lung (Primary?) | 1/14/39 ? |

Other contributory causes of importance: K

Name of operation ..... Date of .....
What test confirmed diagnosis? H + P & X-Ray 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? no
If so, specify .....
(Signed) William Sapsin, M. D.
(Address) City Hospital No. 1

(Licensed Embalmer's Statement on Reverse Side)

## 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 Howard T. Rowland

Licensed Embalmer No. 3114

P. O. Address Orono Me

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

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