

MAY 10 1939

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

13868
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Frank Primary Registration District No. 1002
 (c) City St. Louis (d) Street No. 1700 Sun Dept Registered No. 1622 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME James Agapides
 (a) Residence, No. 435 W 15 St 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (write the word)
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown
 7. AGE YEARS 65 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 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) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-15-39
 22. I HEREBY CERTIFY, That I attended deceased from 4-10-39, 19... to 4-15-39, 19...
 I last saw him alive on 4-15-39, 19... Death is said to have occurred on the date stated above, at 5:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Terminal Broncho pneumonia Date of onset _____
 Other contributory causes of importance:
Cardiac hypertrophy; W. coronary sclerosis; Chronic vascular nephritis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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? _____
 If so, specify _____
 (Signed) P. H. De Maria M. D.
Asst. Reg. H. C. Sun Dept (A. M. R.)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 13. NAME unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 17. INFORMANT (ADDRESS) Record Clerk, St. Mary's
 18. BURIAL, CREMATION, OR REMOVAL St. Mary's DATE 4-17-39
 19. FUNERAL DIRECTOR (ADDRESS) 538 Campbell St
 20. FILED Apr 17 1939 Th. M. Grome Local Registrar.

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

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.

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 to comply with the above constitutes grounds for revocation of license.)

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