

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 1178

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Richmond Heights  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis Co. Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution none  
 In this community twenty years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
 (c) City or town Richmond Heights  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1412 Big Bend Rd  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 27 years.

3. (a) PRINT FULL NAME CHRIS D BALDAS  
 (b) If veteran, name war No  
 (c) Social Security No. 494-01-0423

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 1st  
 year 1939 hour 11:30 minute AM  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Loretta Baldas  
 6. (c) Age of husband or wife if alive 45 years  
 7. Birth date of deceased August 12 1893  
 (Month) (Day) (Year)

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

8. AGE: Years 55 Months 10 Days 19 If less than one day hr. min.

Immediate cause of death \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Birthplace Desocilla Greece  
 (City, town, or county) (State or foreign country)

**Coronary occlusion**

10. Usual occupation Operator Public Service  
Public Service

Due to Chronic myocarditis

MOTHER, FATHER  
 12. Name James Baldas  
 18. Birthplace Desocilla Greece  
 14. Maiden name Unknown  
 15. Birthplace Desocilla Greece  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

16. (a) Informant's own signature George Baldas  
 (b) Address 2104 Patombae st  
 17. (a) Calvary Cem (b) Date thereof 5-5-39  
 (Burial, or other) (Month) (Day) (Year)

Other conditions (Include pregnancy within 3 months of death) 93c

(c) Place: burial or cremation Calvary Cemetery  
 18. (a) Signature of funeral director Watson - Boelge  
 (b) Address 657 3/4 Clayton Bldg  
 19. (a) JUL - 3 1939 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury 11  
 23. Signature John O'Connell (M. D. or other)  
 Address Coroner of St. Louis County, Mo. Date signed \_\_\_\_\_

STATE OF MISSISSIPPI  
BOARD OF EMBALMERS

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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.....

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.**