DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 15 1941 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40328

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 10099

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. John's Sta. (If outside city or town limits, write "RURAL") N.R.
(d) Street No. 3448 Brown Rd. (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Peter Sakellarios
3. (b) If veteran, name war Unknown
3. (c) Social Security No. _____
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. (Month) 23 (Day) 1899 (Year)
8. AGE: Years 41 Months 3 Days 14 If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) Greece 7 (State or foreign country)
10. Usual occupation Cook 7
11. Industry or business Clar-Del Restaurant
MOTHER FATHER
12. Name George Sakellarios 7
13. Birthplace _____ (City, town, or county) Greece (State or foreign country)
14. Maiden name Sotera Galis
15. Birthplace _____ (City, town, or county) Greece (State or foreign country)
16. (a) Informant John Sakellarios
(b) Address 3448 Brown Rd.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/40 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cem.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) 9 1940 (Date received local registrar) (b) J. H. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7th day Dec. year 1940 hour 10:30 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from Dec 2, 1940, to Dec 7th, 1940, that I last saw him alive on Dec 7th, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Ruptured jejunal ulcer	
Due to Gastro-jejunal ulcer	
Due to	
Other conditions Peritonitis (Include pregnancy within 3 months of death)	
Major findings: Of operations Perforated gastro-jejunal ulcer	
Of autopsy None done	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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 —
23. Signature J. G. Probstein (M. D. or other) M.D.
Address 4500 Olive Date signed 12/9/40

(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.....

Licensed Embalmer No. 2971

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.