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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 28 1943
Registration District No. **318**

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

State File No. _____
Registrar's No. **3569**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days**
In this community **45 YRS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis, Mo.** (If outside city or town limits, write "RURAL")
(d) Street No. **836 BROOKLYN** (If rural, give location)
(e) Citizen of foreign country? **YES** (Yes or No)
If yes, name country **ARMENIA**

3. (a) PRINT FULL NAME **Mike Milkonian**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **UNKN. IX 0 1904** (Month) (Day) (Year)

8. AGE: Years **about 70** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **ARMENIA** (City, town, or county) (State or foreign country)

10. Usual occupation **NIL**

11. Industry or business _____

MOTHER FATHER { 12. Name **MIKE**
13. Birthplace **ARMENIA** (City, town, or county) (State or foreign country)
14. Maiden name **SARAH**
15. Birthplace **ARMENIA** (City, town, or county) (State or foreign country)

16. (a) Informant **EMILY HALOFTIS**
(b) Address **4048 1/2 NO BROADWAY**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **4 16 43** (Month) (Day) (Year)
(c) Place: burial or cremation **ST. PETERS CEM.**

18. (a) Signature of funeral director **DEIDER NIEDER**
(b) Address **1936 ST. LOUIS AVE**

19. (a) **APR 16 1943** (Date received local registrar) (b) **J. J. Baker** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **15**, year **1943** hour **4:00** minute **A.** M.
21. I hereby certify that I attended the deceased from **April 13, 1943** to **April 15, 1943**
that I last saw him alive on **April 15, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**
Due to _____
Due to **30 y** _____
Other conditions **date specific**
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy **Refused**

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 **Frank Hamburg** (M. D. or other) **MD**
Address **1515 Lafayette Avenue**, Date signed **4/15/43**

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.....
No Embalming....., 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, fact should be so stated above.