. S. No. 2
OM—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 2 - 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30468

State File No. 8500

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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: 7925 A CHURCH RD. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE (Specify whether In this community years, months or days) 7 YR.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County

(c) City or town ST LOUIS MO. (If outside city or town limits, write "RURAL")

(d) Street No. 7925 A CHURCH RD. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ROSE TOROIAN

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ROBERT TOROIAN

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased JULY (Month) 10 (Day) 1903 (Year)

8. AGE: Years 40 Months 2 Days 13 If less than one day hr. min.

9. Birthplace ISTANBUL (City, town, or county) TURKEY (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name VARTAN SHAZADIAN
13. Birthplace TURKEY (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ARZOOHEE UNKNOWN
15. Birthplace TURKEY (City, town, or county) (State or foreign country)

16. (a) Informant Robert Toroian

(b) Address 7925 A Church Rd.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 28 1943 (Month) (Day) (Year)

(c) Place: burial or cremation BELLEFONTAINE CEM.

18. (a) Signature of funeral director Diedrich F. HOME

(b) Address 8319 Halls Ferry RD.

19. (a) SEP 26 1943 (Date received local registrar) (b) J. F. Breneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 23 year 1943 hour 8 30 minute a M.

21. I hereby certify that I attended the deceased from Sept 1 1943 to Sept 23 1943 that I last saw her alive on Sept 22 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Incarceration — Intestinal obstruction —	3 mo.
Due to Carcinoma of intestine Ladder, uterus —	3 yrs.
Due to Primary site uterus.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Carcinoma	
Of autopsy	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. A. Knight M.D. (M. D. or other)

Address 8201 N Broadway Date signed 9/20/43

(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. 35775

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.