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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

189
State File No. _____
Registrar's No. 100

Registration District No. 318 Primary Registration District No. 1003

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
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. Eleven days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Nick Kolias
3. (b) If veteran, name war None
3. (c) Social Security No. 497-18-5951

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive About 1871 years
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 72 hr. min.

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

10. Usual occupation Dishwasher

11. Industry or business Maryland Cafeteria

MOTHER FATHER

12. Name Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Steve Kolias
(b) Address 4700 Washington Blvd.

17. (a) Burial (b) Date thereof. 1-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery
18. (a) Signature of funeral director Albert H. Hoppe, Inc.
(b) Address 4700 Washington Blvd.

19. (a) JAN 5 1944 (b) J. F. Brudeck
(Date received and signed) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 925
(d) Street No. 608 Elm St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 21
year 1944 hour 11:40 minute _____ M.
21. I hereby certify that I attended the deceased from December
22, 1943 to January 1, 1944;
that I last saw him alive on January 1, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
lobar pneumonia
Due to _____
Due to _____
Other conditions senile psychosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy Not done

Duration _____
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)
Mean of injury _____
23. Signature Frank J. ... (M. D. or other) _____
Address 1515 Lafayette Date signed 1/3/44

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

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.....

Albert G. Hoffe

..... Licensed Embalmer No.....

2971

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.