

No. 2  
-5-43  
17-39  
X36671

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

FILED JAN 20 1944  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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:  
Christian 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)

3. (a) PRINT FULL NAME James Petropoulos

3. (b) If veteran, name war None

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Anastasia Petropoulos 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 25, 1883  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

60 3 10 hr. \_\_\_\_\_ min.

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

10. Usual occupation Cook

11. Industry or business \_\_\_\_\_

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 Mrs. Tombras

(b) Address 6338 San Bonita

17. (a) Burial (b) Date thereof 1-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Albert H. Hoppe, I.

(b) Address 4700 Washington Blvd.

19. (a) JAN 7 1944 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 050

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 601 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 Jan day 5  
year 1944 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan 29, 1943, to Jan 5, 1944, that I last saw him alive on Jan 5, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Cardio vascular renal disease

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

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

Other conditions 131  
(Include pregnancy within 3 months of death)

PHYSICIAN

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

Of autopsy Cardio vascular renal disease

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? \_\_\_\_\_

(c) While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

Signature Halcyon (M. D. or other) M.D.

Address 5074 N. Union Date signed 1-7-44

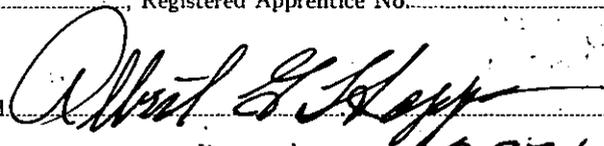
**STATEMENT BY LICENSED EMBALMER**

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 with the above constitutes grounds for revocation of license.)**

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