

FILED NOV 15 1944

318

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

1003

Registrar's No. 9497

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-Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

also known as

3. (a) PRINT FULL NAME John Mavros - Mavrodes

3. (b) If veteran, name was None

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Minnie Mavros

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased May 3 1886  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
58	6	3	_____ hr. _____ min.

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

10. Usual occupation Ice Cream Peddler

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

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 Minnie Mavros

(b) Address 1809a Delmar Ave.

17. (a) Burial (b) Date thereof 11-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 4700 Washington Blvd.

19. (a) NOV 9 1944 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1809a Delmar Ave.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6th  
year 1944 hour 9:45 minute A. M.

21. I hereby certify that I attended the deceased from 11/3/44  
to Nov. 6th 1944

that I last saw him alive on Nov. 6th 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

Due to Hypertension

Due to 83

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature E. W. C. ... (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Date signed 11/6/44

2676

2676

---

---

**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..... *W. Wilkins*.....  
Licensed Embalmer No..... *3575*.....

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.**