

FILED JUN 9 1945

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4315**

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:
1008 Hickory St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 48 Years In St. Louis
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1008 Hickory St
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

ANNIE SARKIS

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Joseph Sarkis 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Aug. 3rd 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 9 28 hr. min.

9. Birthplace SYRIA (City, town, or county) (State or foreign country)
At Home

10. Usual occupation.....

11. Industry or business Housewife

12. Name Michael Massud

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

14. Maiden name.....

15. Birthplace Syria (City, town, or county) (State or foreign country)

16. (a) Informant Sax Sarkis

(b) Address 1008 Hickory St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4/45
(Month) (Day) (Year)

(c) Place: burial or cremation Old S.S. Peter & Paul

18. (a) Signature of funeral director Thos Curtis & Son

(b) Address 2906 Gravois Ave.

19. (a) JUN 2 1945 (Date received local registrar) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1945 hour 10 minute 00 P.M. A.M.

21. I hereby certify that I attended the deceased from 5-30, 1945, to 5-31, 1945
that I last saw her alive on 5-31, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death:
Myocardial degeneration
Chronic nephritis
and
and
Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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)
Means of injury.....

23. Signature [Signature] (M. D. or other)

Address [Address] Date signed [Date]

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 David Von Fasson
Licensed Embalmer No. 4242
P. O. Address 2906 Graves

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.