S. No. 2
M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32614

State File No.

FILED NOV 14 1945

Registration District No. 147 Primary Registration District No. 1002 Registrar's No. 4478

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or ~~institution~~ LAKESIDE HOSPITAL O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 8 WEEKS (Specify whether
In this community 42 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4436 TROOST AVENUE 8
(If rural, give location)

(e) Citizen of foreign country? YES (Yes or No) 0

If yes, name country GREECE

3. (a) PRINT FULL NAME MR PETER COPULOS, SR.

3. (b) If veteran, name war NO

3. (c) Social Security No. none

4. Sex MALE 0

5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. ANNA COPULOS

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

7. Birth date of deceased AUGUST-15-1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
66	2	14	hr. min.

9. Birthplace (City, town, or county) GREECE 6 (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business RESTAURANT OPERATOR

FATHER
12. Name PARRIS COPULOS 1
13. Birthplace (City, town, or county) GREECE 6 (State or foreign country)

MOTHER
14. Maiden name UNKNOWN DEMETRI
15. Birthplace (City, town, or county) GREECE 6 (State or foreign country)

16. (a) Informant MRS. ANNA COPULOS

(b) Address 4436 TROOST AVENUE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT-31-1945 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ MT. MORIAH CEMETERY

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 10-31-45 (Date received local registrar) (b) S Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 29TH year 1945 hour 9 minute 05 A.M.

21. I hereby certify that I attended the deceased from August 31, 1945 to Oct 29, 1945 that I last saw him alive on Oct 29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis — Duration Aug 31-1945

Due to Arteriosclerosis — Indefinite Many yrs

Coronary Sclerosis — Many yrs

Due to Arteriosclerosis

Myocardial decompensation

Other conditions Arterial Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations 93 e

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 2

23. Signature A M Adkins D.O. (M. D. or other)

Address 428 Lee Bldg Date signed Oct 29-1945

(Licensed Embalmer's Statement on Reverse Side)

428 Lee Bldg

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC Mo.

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.