

FILED DEC 7 1945

STANDARD CERTIFICATE OF DEATH 1003

State File No. _____

Registration District No. _____

318

Primary Registration District No. _____

Registrar's No. 10291

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If inside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
(Specify whether years, months or days) 30 years
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4275 Sabadie
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John Demitroff

3. (b) If veteran, name war no

3. (c) Social Security No. 499-034802

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 15, 1897
(Month) (Day) (Year)

8. AGE: Years 48 Months 10 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Cook

11. Industry or business May Fair Hotel

12. Name don't know

13. Birthplace Greece (City, town, or county) in (State or foreign country)

14. Maiden name don't know

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

16. (a) Informant Christy Demitroff

(b) Address 4275 Sabadie St

17. (a) Burial (b) Date thereof 11/29/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Joseph L. Howard

(b) Address 1619 Grand

19. (a) NOV 23 1945 (b) G. F. Bredenk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 26
year 1945 hour 4 minute a M.

21. I hereby certify that I attended the deceased from 9-14, 1945, to 11-26, 1945
that I last saw him alive on 11-25, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus for which his leg was amputated upper + mid 1/3 left thigh

Other conditions U1
(Include pregnancy within 3 months of death)

Major findings: gangrene of left leg
Of operations _____
Of autopsy _____

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) (e) Means of injury _____

23. Signature R. H. Cain (M. D. or other) 11-20-45
Address 3902 Fairview Date signed _____

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

MOTHER FATHER

MAR 25 1947

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..... *J. W. Wilkinson*
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.