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45853
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25551

FILED JUL 26 1946

State File No. _____
Registrar's No. 6344

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(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 _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Law
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1616 FRANKLIN 259
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME IAROTHEOS MOUSTAKAS

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife BASILIKE MOUSTAKAS 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased ABOUT 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
ABOUT 73 - - - - hr. min.

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

10. Usual occupation RETIRED LABORER

11. Industry or business _____

MOTHER FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN G
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN G
(City, town, or county) (State or foreign country)

16. (a) Informant SAM PANOS I

(b) Address 4506 W. PAPIN ST.

17. (a) BURIAL (b) Date thereof 7-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation ST. MATTHEWS CEM.

18. (a) Signature of funeral director Heavenly Chapel

(b) Address 4700 Washington Blvd

19. (a) JUL 18 1946 (b) J. T. Shedd
(Date received for filing) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 15
year 1946 hour 9:15 minute P M.
21. I hereby certify that I attended the deceased from July 14
6 to July 15 19 46
in July 15 19 46
that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy None performed

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? _____

23. Signature Robert E. Seel (M. D. or other) _____
Address 1515 Lafayette Avenue Date signed 7/16/46

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.....

Elmo R. Galweil

Licensed Embalmer No..... *4077*

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.