

FILED MAY 1 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 4044

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: **Enroute City Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

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. **111 No. 16th St.**
(If rural, give location) **2517 9**
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **Kyriakes Lazarides**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **About 1891**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 56 hr. min.

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

10. Usual occupation **Porter**

MOTHER FATHER { 11. Industry or business _____
12. Name **Unknown** 9
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Pete Fontas**
(b) Address **1504 Chestnut St.**

17. (a) **Burial** (b) Date thereof **4-19-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Cemetery**

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

(b) Address **4700 Washington Blvd.**

19. (a) **APR 18 1947** (b) **J. P. Redek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **17**
year **1947** hour **12** minute **25** M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;

that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to **Coronary Arteriosclerosis**

Due to **Coronary Sclerosis**

Other conditions _____

(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 **Joseph E. [Signature]** 3
Address **Dep. Coroner** Date signed **4/18/47**

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

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

John S. Pennek

Licensed Embalmer No. *4194*

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.