

FILED APR 7 1948

Registration District No.

Primary Registration District No. **1003**

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: **None At Home**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **None**
8560 N. Broadway (Specify whether
 In this community **19 Yr.**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
 (c) City or town **St. Louis Mo.** **17**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **8560 N. Broadway** **9**
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No) **0**
 If yes, name country.....

3. (a) PRINT

FULL NAME **Aroosiag Kalajian**

3. (b) If veteran,

name war **None**

3. (c) Social Security No.

None

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Charles Kalajian** (c) Age of husband or wife if alive **50** years
 7. Birth date of deceased **Sept. 15 1897**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 **6** **9** **1** hr. **1** min.

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

10. Usual occupation **House Wife**

11. Industry or business.....

12. Name **David Tosian**

13. Birthplace **Turkey**
 (City, town, or county) (State or foreign country)

14. Maiden name.....

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

16. (a) Informant **Rose Kalajian**

(b) Address **8560 N. Broadway**

17. (a) **Burial** (b) Date there **March 29 1948**
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Diedrich F. Han**

(b) Address **8319 Halls Ferry Rd**

19. (a) **MAR 27 1948** (b) **J.F. BARDICK**
 (Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **24**
 year **1948** hour **1** minute **45** M.

21. I hereby certify that I attended the deceased from **Sept 1**
1946 to **Mar 24 1948**
 that I last saw her alive on **Mar 23** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Parcome of Stomach 1 yr +**
 Duration

Due to.....

Due to.....

Other conditions **None**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations.....

Of autopsies.....

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?..... Means of injury **0**

23. Signature **Albert J. Senn** M. D. or other **15**

Address **2365 Kearney** Date signed **3/26/48**

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. Cadwell

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.

Registration District No. 314 Primary Registration District No. 1003

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:

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

3. (a) PRINT FULL NAME Arrossia Kalapia
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 49 Months 6 Days..... If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 3-27-1948 (b) J. F. Bronecke (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: March 24 1948
year / 1948 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 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.....
Due to.....
Other conditions..... (include pregnancy within 3 months of death)

Major findings:
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..... (M. D. or other)
Address..... Date signed.....

SUPPLEMENTARY

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

APR 27 1948

5-16338