

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1633

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Koch (rural)  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Robert Koch Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 106 days  
 In this community 45 years  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 500  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 112 South 4th St.  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME POULOS, NICK

3. (b) If veteran, name war No 3. (c) Social Security No. 499-26-3164

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

6. (b) Name of husband or wife Katie Duncan Poulos 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: December 6 1879  
 (Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 25  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

12. Name Efthenio Poulos

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

14. Maiden name Evangelii Apostolo

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

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (b) Date thereof: 7/6/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

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

(b) Address 4700 Washington Blvd.

19. (a) 7-1-48 (b) Cecil A. Z. Shroyer  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1  
 year 1948 hour 2 minute 55 A.M.

21. I hereby certify that I attended the deceased from 3-16-48 19\_\_\_\_ to 7-1-48 19\_\_\_\_  
 that I last saw him alive on 7-1-48 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis Duration 15 yrs  
 (??)

Due to 13 &

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Cor Pulmonale

Major findings:  
 Of operations \_\_\_\_\_  
 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?  
 \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature John T. ... (M.D. or other)

Address Robt. Koch Hospital Date signed 7-2-48

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

MOTHER FATHER

**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 Henry W. Brammer

Licensed Embalmer No. 4200

P. O. Address. St. Louis

**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. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Rural  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Nick Paulsen

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased see (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) see

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. (c) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 7-1-48 (b) Paul J. Sharp MD  
(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: Month \_\_\_\_\_ 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 \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
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? \_\_\_\_\_

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

S-21757