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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38396**
9662
Registrar's No. _____

FILED NOV 19 1948

Registration District No. **818**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri.**
(b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital—Max C. Starkloff**
(If not in hospital or institution, write street number or location) **Memorial**
(d) Length of stay: In hospital or institution **0** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3814 North Newstead Avenue**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME **NICK LOUTAS**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **Unknown**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **5th**
year **1948** hour **2** minute **40 P.M.**
21. I hereby certify that I attended the deceased from **10/29/48**
_____ 19____, to **Nov. 5th** 19____ **48**
that I last saw him alive on **Nov. 5th** 19____ **48**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Evelyn Loutas**
6. (c) Age of husband or wife if alive **49** years
7. Birth date of deceased **December 17 1900**
(Month) (Day) (Year)

Immediate cause of death **Pneumonia**
Duration **10 1/2**
Due to _____
Due to _____

8. AGE: Years Months Days If less than one day
47 **10** **18** hr. min.

Other conditions **Undiagnosed disease of Central Nervous system of operation Hemorrhage from upper Gastrointestinal tract**
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **Zante Greece**
(City, town, or county) (State or foreign country)
10. Usual occupation **Confectionery Owner**
11. Industry or business _____
12. Name **Peter Loutas**
13. Birthplace **Greece**
(City, town, or county) (State or foreign country)
14. Maiden name **Jessie Jaturas**
15. Birthplace **Greece**
(City, town, or county) (State or foreign country)

16. (a) Informant **Evelyn Loutas**
(b) Address **3814 North Newstead Avenue**
17. (a) **Burial** (b) Date thereof **11/9/48**
(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) **NOV 6 1948** (b) **John R. Kasiter**
(Date received local registrar) (Registrar's signature)

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 R. Kasiter**
Address **11-5-48** Date signed _____

1000 5 11 11

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 Elton R Remelius

Licensed Embalmer No. 4283

P. O. Address St Louis, Mo

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.