

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 43357
109307

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		b. COUNTY Roanoke	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Roanoke	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS NR (If rural, give location)	

3. NAME OF DECEASED (Type or Print) ANTONOUS	a. (First)	b. (Middle)	c. (Last) CHRISTOFIS	4. DATE OF DEATH (Month) (Day) (Year) 12-20-49
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) About 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?	10b. KIND OF BUSINESS OR INDUSTRY ?	11. BIRTHPLACE (State or foreign country) Typrus Islandy		12. CITIZEN OF WHAT COUNTRY? Greece

13a. FATHER'S NAME Steve Christofis	13b. MOTHER'S MAIDEN NAME Helen Kostas	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Steve Christofis, Roanoke, Virginia.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration pneumonia following cerebral abscess for paralysis agitans		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 11/25/49	19b. MAJOR FINDINGS OF OPERATION chromal cortex	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Roanoke VA
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 350 X

22. I hereby certify that I attended the deceased from **11/18**, 19**49** to **12/18**, 19**49**, that I last saw the deceased alive on **12/19**, 19**49**, and that death occurred at **11:10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Robert Clemme / per Ed. Smoris (Degree or title)	23b. ADDRESS Medical Arts Bldg St. L. Mo	23c. DATE SIGNED 12/20/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 12-21-49	24c. NAME OF CEMETERY OR CREMATORY unknown	24d. LOCATION (City, town, or county) (State) Roanoke, Virginia.
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DATE REC'D BY LOCAL REG. DEC 21 1949	REGISTRAR'S SIGNATURE J. B. Sasater	25. FUNERAL DIRECTOR'S SIGNATURE C. R. Lupton & Sons, St. Louis, Missouri.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

18950

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.....

.....
working under my personal supervision.

Student Embalmer No.

Signed..... *Arnold W. Schoene*

Signed.....

Student Embalmer

Licensed Embalmer No. *3864*

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.