

FILED SEP 2 1950

STANDARD CERTIFICATE OF DEATH

State File No. **26876**
Registrar's No. **3470**

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 3243 Bellefontaine	

3. NAME OF DECEASED (Type or Print) a. (First) Sofia b. (Middle) _____ c. (Last) GRAMPSAS		4. DATE OF DEATH (Month) (Day) (Year) Aug. 12, 1950	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 10-30-1900
9. AGE (In years last birthday) 49		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) Argos, Greece		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Peter Kalantze	13b. MOTHER'S MAIDEN NAME Helen Kouris	14. NAME OF HUSBAND OR WIFE Sam A. Grampsas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Anthony Grampsas ADDRESS 3243 Bellefontaine, KC, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Metastases		INTERVAL BETWEEN ONSET AND DEATH 6 mos 2 yrs 17 1/2
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Col Uterus		
	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 _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **6/14/46**, 19____, to **8/12/50**, 19____, that I last saw the deceased alive on **8/11/50** and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE James R. Mc [Signature] (Print name or title)	23b. ADDRESS 514 Porter Bldg	23c. DATE SIGNED 8/12/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-11-50	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 8-14-50	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eyler ADDRESS Kansas City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Geo. P. McVay
Porter Bell
34th + Bluff

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 Max H. Kirkendall

Signed.....
Student Embalmer

Licensed Embalmer No. 4632

P. O. Address K. C. 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.