

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 2 1951

State File No. 1469
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		4. STREET ADDRESS (If rural, give location) 1044 Oakview Place	
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) c. (Last) DEMAS			4. DATE OF DEATH (Month) (Day) (Year) Feb. 11 1951
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 23, 1886
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employ water works		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sparta, Greece
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Peter Demas	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Dora Demas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 495-12-4422	
17. INFORMANT'S SIGNATURE OR NAME Dora Demas		ADDRESS 1044 Oakview Place	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myelogenous Leukemia 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		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK? <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 20 ft			
22. I hereby certify that I attended the deceased from 2-7-51, 19, to 2-11-51, 19, that I last saw the deceased alive on 2-11-51, 19, and that death occurred at 11:30 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Albert H. Hoppe, M.D.		23b. ADDRESS 1515 Lafayette Ave.	
23c. DATE SIGNED 2-12-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-14-51	
24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY, LOCAL REG. FEB 13 1951		REGISTRAR'S SIGNATURE J. B. Pasater	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington	

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

ml

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 *ml*

working under my personal supervision.

Student Embalmer No.....

Signed *Wm. Salpeter*

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.