

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22044

State File No. _____

FILED JUN 27 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5090**

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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2820 N. 14th St.		d. STREET ADDRESS (If rural, give location) 26 2820 N. 14th St.	

3. NAME OF DECEASED (Type or Print) a. (First) Gregory b. (Middle) E. c. (Last) Golfinopoulos			4. DATE OF DEATH (Month) (Day) (Year) MAY 30, 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 25, 1896	9. AGE (In years last birthday) 56	10. MONTHS 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY S. G. Adams Co.		11. BIRTHPLACE (City and State or Foreign Country) Rozena, Greece 6	
13a. FATHER'S NAME Elias K. Golfinopoulos			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Verlie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 494-07-4286		17. INFORMANT'S SIGNATURE OR NAME Verlie Golfinopoulos ADDRESS 2820 N. 14th	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Intestinal Nephrosis			INTERVAL BETWEEN ONSET AND DEATH Several years
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			For years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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)	
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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? 592X	
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22. I hereby certify that I attended the deceased from **Feb 17, 1952** to **May 30, 1952**, that I last saw the deceased alive on **May 28, 1952**, and that death occurred at **8:10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Peter A Eck M.D. (Degree or title) U		23b. ADDRESS 4701 S. Down Ave		23c. DATE SIGNED June 2-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-3-52		24c. NAME OF CEMETERY OR CREMATORY National Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	

DATE REC'D BY LOCAL REG. JUN 3 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed John J. Harris
Licensed Embalmer No. 4128

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.