.300
.48

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

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

7317

State File No. 1791

FILED MAR 11 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1791

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Missouri
c. LENGTH OF STAY (In this place): 35 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission.)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo 2262
d. STREET ADDRESS (If rural, give location): 26 2503 a N 10 St

**3. NAME OF DECEASED** (Type or Print)
a. (First): ALEX
b. (Middle):
c. (Last): ALOIAN

**4. DATE OF DEATH** (Month) (Day) (Year): FEBRUARY 14, 1953

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Divorced
**8. DATE OF BIRTH**: 8-14-1888
**9. AGE** (In years last birthday): 64
If under 1 year: Months | Days
If under 24 hrs.: Hours | Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Moulder
**10b. KIND OF BUSINESS OR INDUSTRY**: Semi Steel Co
**11. BIRTHPLACE** (City and State or Foreign Country): Armania
**12. CITIZEN OF WHAT COUNTRY?**: 0

**13a. FATHER'S NAME**: Zaker Aloian
**13b. MOTHER'S MAIDEN NAME**: Salviy Bogasian
**14. NAME OF HUSBAND OR WIFE**: Nazig Aloian( Divoreed)

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): ----------
(If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**: 497-01-4950
**17. INFORMANT'S SIGNATURE OR NAME**: Mr Stanley Aloian
**ADDRESS**: 4926 Rosalie Av

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infectious hepatitis c

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) subacute yellow

DUE TO (c) atrophy of the liver

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**: 092X
**20. AUTOPSY?** YES ☑ NO ☐

**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 ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* 1-28-53, 19____, *to* 2-14-53, 19____, *that I last saw the deceased alive on* 2-14-53, 19____, *and that death occurred at* 12:50P *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): John M Wallace M.D.
**23b. ADDRESS**: 1515 Lafayette Avenue
**23c. DATE SIGNED**: 2-16-53

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: 2-17-53
**24c. NAME OF CEMETERY OR CREMATORY**: Memorial Park Cemetery
**24d. LOCATION** (City, town, or county) (State): St. Louis, Co

DATE REC'D BY LOCAL REG.: FEB 16 1953
REGISTRAR'S SIGNATURE: J. Earl Smith, M.D.
**25. FUNERAL DIRECTOR'S SIGNATURE**: Goodhart-Goodhart
**ADDRESS**: 2228 St. Louis, Av

(Licensed Embalmer's Statement on Reverse Side)

## 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 Albert E. Hoppe

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.