

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13641

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2947**

1. PLACE OF DEATH
a. COUNTY Missouri

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **ST. LOUIS, MISSOURI** c. LENGTH OF STAY (In this place) d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **ST. LOUIS CITY HOSPITAL** e. STREET ADDRESS (If rural, give location) **24 1934 Arsenal St. 2249**

3. NAME OF DECEASED a. (First) **GUS** b. (Middle) **(Constantinos)** c. (Last) **KAPPARIS** 4. DATE OF DEATH (Month) (Day) (Year) **MARCH 30, 1954**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Divorced** 8. DATE OF BIRTH **May 21, 1894** 9. AGE (In years last birthday) **59** 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) **Retired waiter** 10b. KIND OF BUSINESS OR INDUSTRY **Restaurant** 11. BIRTHPLACE (City and State or Foreign Country) **Zante Greece** 12. CITIZEN OF WHAT COUNTRY? **Greece**

13a. FATHER'S NAME **Unknown** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Jennie Kapparis**

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. **306-28-4489** 17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Dorothy Cladis, 1934 Arsenal St.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Bronchial Asthma**
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) **Chronic Pulmonary Disease**
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c)
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 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) **241X**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 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 **3-28-54**, 19**54**, to **3-30-54**, 19**54**, that I last saw the deceased alive on **3-30-54**, 19**54**, and that death occurred at **6:35P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Walter B. Zimmerman M.D.** 23b. ADDRESS **1515 Lafayette Avenue** 23c. DATE SIGNED **3-31-54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **4-2-54** 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. **APR 1 1954** REGISTRAR'S SIGNATURE **Albert H. Hoppe** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **4700 Washington.**

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.....
Signature of Student Embalmer

Signed.....
Edmond H. Penelux

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.