

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13695

State File No. ....  
Registrar's No. .... 3265

FILED APR 28 1955

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1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. ....		Registrar's No. ....		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>			c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>ST. LOUIS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>5 5735 BARTMER</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>PAUL</u>			b. (Middle) <u>BOGHOS</u>		c. (Last) <u>MOMIGONIAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 10, 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>UNKNOWN</u>		9. AGE (In years last birthday) <u>APPROX 68</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 24 HRS. Hours _____	Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>TURKISH ARMENIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>JOHN MOMIGONIAN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Salmeq Boghosian St. Louis, Mo.</u>						ADDRESS _____
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) <u>Carcinoma of the Stomach</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause lost. DUE TO (b) <u>Perforation of Stomach</u> 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 <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>151X</u>						
22. I hereby certify that I attended the deceased from <u>3-22-55</u> , 19____, to <u>4-10-55</u> , 19____, that I last saw the deceased alive on <u>4-10-55</u> , 19____, and that death occurred at <u>4:30A</u> m., from the causes and on the date stated above.										
23a. SIGNATURE <u>Edgar B. Citter</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>			23c. DATE SIGNED <u>4-11-55</u>			
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Removed</u>		24b. DATE <u>APRIL 10, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Synsch Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Edwardsville Illinois</u>				
DATE REC'D BY LOCAL REG. <u>APR 12 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Mercer</u> ADDRESS <u>Shawnee City, Illinois</u>					

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

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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 *Charles C Mercer*

Licensed Embalmer No. *2988*

P. O. Address *Granite City*

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.