

FILED AUG 2-1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23604

6140

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

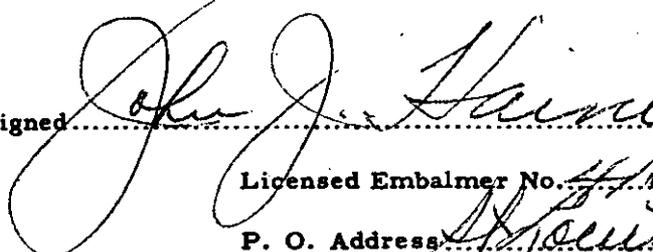
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hospital		e. STREET ADDRESS (If rural, give location) 6001 Jamieson Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) Constantine c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) July 14, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 19, 1885
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant Owner	11. BIRTHPLACE (City and State or Foreign Country) Koritzza, Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND/OR WIFE Evanthia Constantine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No.		16. SOCIAL SECURITY NO. 487-36-7595	
17. INFORMANT'S SIGNATURE OR NAME Feeny Constantine, 3116 Eads Ave.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Myocardial Infarction arteriosclerotic heart disease cardiac failure	
19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 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.		INTERVAL BETWEEN ONSET AND DEATH Sudden 2 wks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. 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? 4200		22. I hereby certify that I attended the deceased from June 14, 1955 , to July 14, 1955 , that I last saw the deceased alive on July 8, 1955 , and that death occurred at 7:10 P.M. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Arthur K. Trustel M.D.		23b. ADDRESS 1850 Kingshighway	
23c. DATE SIGNED 7-15-55		24. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24a. DATE 7-18-55		24b. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	
24c. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	
25. ADDRESS 4700 Washington.		DATE REC'D BY LOCAL REG. JUL 16 1955	
REGISTRAR'S SIGNATURE Carl Smith - MD		26. (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.....
Signature of Student Embalmer

Signed ,
Licensed Embalmer No. 
P. O. Address 

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.