FILED SEP 29 1955

STANDARD CERTIFICATE OF DEATH

State File No. 31323

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7576

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis
c. LENGTH OF STAY (in this place): 9days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DePaul Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Old Mines
d. STREET ADDRESS (If rural, give location): Rd 1

3. NAME OF DECEASED (Type or Print)
a. (First): Julia
b. (Middle): Mary
c. (Last): Pashia

4. DATE OF DEATH (Month) (Day) (Year): 8 25 1955

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 1-30-1885
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months 6, Days 25 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Old Mines, Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Paschal DeClue
13b. MOTHER'S MAIDEN NAME: Maby Coleman
14. NAME OF HUSBAND OR WIFE: Roussan Pashia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Mrs Walter Boyer
ADDRESS: Cadet, Rt. 1 Mo

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) Hypertension Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertrophied Prostate — 2 wks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis — Yes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 443 X
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* 8/14, 1955, *to* 8/25, 1955, *that I last saw the deceased alive on* 8/25, 1955 *and that death occurred at* 1:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature]
(Degree or title): MD
23b. ADDRESS: 4161 Lindell
23c. DATE SIGNED: 8/29/55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-27-1955
24c. NAME OF CEMETERY OR CREMATORY: St Joachims Cemetery
24d. LOCATION (City, town, or county) (State): Old Mines. Mo

DATE REC'D BY LOCAL REG.: AUG 29 1955
REGISTRAR'S SIGNATURE: J Carl Smith MD
MJB
25. FUNERAL DIRECTOR'S SIGNATURE: Archie W. Smith
ADDRESS: Potosi. Mo
(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 Mary M. Smith
Licensed Embalmer No. 4394
P. O. Address Potosi, Mo

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

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