

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 25 1957

318

1003

STATE FILE NUMBER

2999

34

Registration District No. Primary Registration District No. 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 (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1. | | Length of stay in 2069.0 | STREET ADDRESS 5653 Wells Ave. | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL (Mike) John PAVLAKIS | | | 4. DATE OF DEATH Month Day Year JAN. 1, 1957 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 23, 1886 | | 9. AGE (In years last birthday) 70 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | 11. BIRTHPLACE (City and state or country) Kytheria, Greece | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME John Pavlakis | | | 14. MOTHER'S MAIDEN NAME Frosine Lourondos | | |
| 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. 490-36-7986 | | 17. INFORMANT Address Bertha Pavlakis, 5653 Wells Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) Pyelonephritis | | | | | |
| DUE TO (c) Diabetes mellitus | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 260x | | |
| 20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 12/23/56 to 1/1/57 and last saw her alive on 1/1/57 Death occurred at 3:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Thomas C. Roach M.D. | | | 22b. ADDRESS 1515 LAFAYETTE AVE. | | 22c. DATE SIGNED 1/2/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-4-58 | 23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | | 25. DATE RECD. BY LOCAL REG. JAN 3 1957 | | 26. REGISTRAR'S SIGNATURE Carl Smith M.D. <i>m 86.</i> |

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 *Robert M. Murray*.....
Licensed Embalmer No. *3749*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.