

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38742

STATE FILE NUMBER

FILED OCT 16 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2370

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Affton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Affton 4810</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Millers Nursing Home</b>			Length of stay in 1b <b>1 Mo.</b>		d. STREET ADDRESS (If outside, give location) <b>7109 Whitworth Dr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Lazarov</b> Last <b>Lazarov</b>				4. DATE OF DEATH Month <b>9</b> Day <b>18</b> Year <b>57</b>					
5. SEX <b>Male 0</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 15, 1879</b>		9. AGE (In years last birthday) <b>78</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer - Ret.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (City and state or country) <b>Temeswar-Austria 4</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>Hungary</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>493-24-7541</b>		17. INFORMANT <b>Mrs. Katherine Cooney</b> Address <b>7109 Whitworth Dr.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>15 1/2</b> <b>9</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus (controlled)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)						
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 <b>1/26/56</b> to <b>9/18/57</b> and last saw her alive on <b>9/16/57</b> . Death occurred at <b>1:00</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Herbert B. Donike MD</b> (Degree or title)			22b. ADDRESS <b>689 E. Big Bend, 19,</b>			22c. DATE SIGNED <b>9/20/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>9/21/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>			
24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>			ADDRESS <b>1905 Union</b>		25. DATE RECD. BY LOCAL REG. <b>9-20-57</b>		26. REGISTRAR'S SIGNATURE <b>Herbert B. Donike MD</b>		

(Licensed Embalmer's Statement on Reverse Side)

asc

Health, Welfare, Public Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. John V. King  
689 E. Big Bend

Hrs. Thurs. all PM  
Fri. 1 - 3

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 *Albert R. Thompson* .....

Licensed Embalmer No. *42* .....

P. O. Address *H. J. ...* .....

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.