

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029002

STATE FILE NUMBER

3986

FILED SEP 5 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		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. Joseph Hosp.		Length of stay in 1b 44 yrs	d. STREET ADDRESS 2635 E. 29th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First John Middle G. Last Alexiou			4. DATE OF DEATH Month Aug. Day 18 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1870 Jan. 13, 1889	9. AGE (In years last birthday) 67 88	IF UNDER 1 YEAR Months 8 Days 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Sole Cleaning Business	11. BIRTHPLACE (City and state or country) Kansas, Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME GUST ALEXIOU		13b. MOTHER'S MAIDEN NAME Rosemary Droulis Rose Russo		14. NAME OF HUSBAND OR WIFE PERSEFONE ALEXIOU	
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. 488-22-3350	17. INFORMANT Address Mrs. Persefone Alexiou, of 2635 E. 29th		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma					INTERVAL BETWEEN ONSET AND DEATH about 10 months 1621
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 5-26-58 to 8-18-58 and last saw him her alive on 8-18-58 Death occurred at 10:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>D. J. Cutcliff M.D.</i> (Degree or title) D			22b. ADDRESS M.D., 1222 McGee St., K.C., Mo.		22c. DATE SIGNED 8-18-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-20-58	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR Melody-McGilley-Eylar Funeral Home		ADDRESS Woodland-Linwood	25. DATE RECD. BY LOCAL REG. 8-19-58	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>	

All diseases in Part I must be causally related. **Stomach 8/9/11/10/106/156** caused by affidavit of funeral home. **USE ONLY BLACK INK OR RIBBON TYPEWRITE-IF POSSIBLE-OR BLUE INK.** **8/20/58**

MEDICAL CERTIFICATION



Wm. D. M. Cutcliffe
1222 Maple
Sta 1-2388

2-4-1917

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 *James E. DeClerna*

Licensed Embalmer No. *1573*

P. O. Address *K.C. Mo*

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.