

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030599  
STATE FILE NUMBER

FILED SEP 8 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8164

S. 300  
1-57

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>East St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Stones Nursing Home</u>		Length of stay in lb <u>2 1/2 mos.</u>	3. STREET ADDRESS (If outside, give location) <u>222 Douglas Avenue</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SETRAK</u> Middle <u>KEOKOR</u> Last <u>KARIBIAN</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1879</u>	9. AGE (In years) <u>79</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Molder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wadsworth Co.</u>	11. BIRTHPLACE (City and state or country) <u>Armenia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Keokor Karibian</u>		13b. MOTHER'S MAIDEN NAME <u>Mariam (Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Agavnic Karibian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>329-10-3741</u>		17. INFORMANT <u>George Karibian - St. Louis, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive</u> <u>Cardiovascular Disease</u> <u>Cerebral Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic myocarditis with</u> <u>Cardiac Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>Pulmonary Edema 3 days</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks</u> <u>10 weeks</u> <u>10 weeks</u>
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.) <u>443x</u>		
20c. TIME OF INJURY Hour _____ 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.) <u>—</u>		20f. CITY, TOWN, OR LOCATION <u>—</u>		COUNTY	STATE
21. I attended the deceased from <u>6-11-58</u> to <u>8-21-58</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>8-20-58</u> Death occurred at <u>10:00 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>A. J. Raenold</u>				22b. ADDRESS <u>4390 West Pine Bl.</u>	
22c. DATE SIGNED <u>8-22-58</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>8-24-58</u>		<u>St. Clair Mem. Park</u>	
23d. LOCATION (City, town, or county)		23e. STATE			
<u>St. Clair Cty., Illinois</u>		<u>Illinois</u>			
24. FUNERAL DIRECTOR <u>John J. Murphy</u>			25. DATE RECD. BY LOCAL REG. <u>AUG 22 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> S.P.

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 ..... *Not Embalmed* ..... Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed ..... *Joseph J. [Signature]* .....

Licensed Embalmer No. *7541*

P. O. Address *E. St. Louis, 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.