

Dept. Health,
U. S. Public
Health Service

FILED VS DEC 11 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-041900

STATE FILE NUMBER

211252

Registration District No. Primary Registration District No. Registrar

V. S. 300
Rev. 1-57

15
71
1208

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
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 Illinois b. COUNTY Madison		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Granite 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 Jewish		Length of stay in 1b 4 weeks	d. STREET ADDRESS (If outside, give location) 945 Niedringhaus Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DORA GUIROFF			4. DATE OF DEATH Month Day Year 12 2 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-92	9. AGE (In years last birthday) OF UNDER 1 YEAR IF UNDER 24 HRS. 67 Months Days 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 none	11. BIRTHPLACE (City and state or country) Macedonia, Greece		12. CITIZEN OF WHAT COUNTRY? Greece
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Etcho Guiroff	
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. 333-01-9699-D	17. INFORMANT Address Granite City, Ill Louise Shambro 945 Niedringhaus 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 monocytic Leukemia					INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					204.2
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? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE 57 <input type="checkbox"/> <input type="checkbox"/> <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 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 11/1/59 to 12/2/59 and last saw her alive on 12/2/59 Death occurred at 11:50 p m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John H. Holt M.D.			22b. ADDRESS 216 S. Kingshighway St. Louis		22c. DATE SIGNED 12/3/59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12-5-59	23c. NAME OF CEMETERY OR CREMATORY Sunset Hill		23d. LOCATION (City, town, or county) (State) Madison County, Illinois	
24. FUNERAL DIRECTOR John L. Sedlack Granite City, Illinois		25. DATE RECD. BY LOCAL REG. DEC 4 1959		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

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 *John T. Sedlach*.....

Licensed Embalmer No. *3747*.....

P. O. Address *Madison, Ill.*.....

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.