

FEDERAL BUREAU OF INVESTIGATION
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 25 1960

=60-021614

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5034 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>1 Day</u>	c. CITY OR TOWN <u>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>Lutheran Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3654 Dunnica St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L.</u> Last <u>Theodorow</u>	4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1960</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/96</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery Manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Baking</u>	11. BIRTHPLACE (City and state or country) <u>- Greece</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Anna Theodorow</u>
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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>489-18-9904</u>	17. INFORMANT <u>Mrs. Anna Theodorow, Dunnica</u> Address <u>3654</u>
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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>Hemorrhage</u> <u>Gastric Ulcer</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>570.0</u> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? <u>Yes</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.)
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20c. TIME OF INJURY Hour <u>11</u> a.m. p.m.	Month, Day, Year <u>5-10-60</u>
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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 <u>St. Louis</u> COUNTY <u>St. Louis</u> STATE <u>Mo.</u>
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21. I attended the deceased from <u>10-27-53</u> to <u>5-10-60</u> and last saw <u>him</u> alive on <u>5/10/60</u> Death occurred at <u>11 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. M. Cronberg M.D.</u> (Degree or title)	22b. ADDRESS <u>3701 Grandel Sq</u>	22c. DATE SIGNED <u>5/12/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>5/13/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
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24. FUNERAL DIRECTOR <u>Drehmann-Harral, 1905 Union Blvd.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAY 13 1960</u>	26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3701 Delmar-Grand Del Square
Fo 7-5661
Hrs. 12:30-2 P.M. Thurs.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert R. Thompson

Licensed Embalmer No. 4257

P. O. Address St. Louis

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.