

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028101

FILED VS JUL 22 1960

318 Primary Registration District No. 1003

Registrar's No. 6823

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5-yrs.</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>3225 N. Florissant Ave. Little Sisters of Poor</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3225 N. Florissant</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Benakis</b> Last <b>Benakis</b>				4. DATE OF DEATH <b>July 6, 1960</b> Month <b>July</b> Day <b>6</b> Year <b>1960</b>				
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/10/1896</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>New York, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>James Benakis</b>			13b. MOTHER'S MAIDEN NAME <b>Angelina Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Anna James</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Sister Germain, 3225 N. Florissant Ave.</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>Lymphatic Leukemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>???</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)								
DUE TO (c) <b>204.0</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
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 <b>8:45 pm.</b> Month, Day, Year <b>May 12, 1960</b>		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>May 12, 1960</b> to <b>July 6, 1960</b> and last saw her/him alive on <b>July 1, 1960</b> Death occurred at <b>8:45 pm.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deceased or title) <b>Bernard H. Hottel M.D.</b>				22b. ADDRESS <b>2435 N. Grand Blvd</b>		22c. DATE SIGNED <b>7-7-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/8/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>			
24. FUNERAL DIRECTOR <b>Arthur J. Homelly</b>			ADDRESS <b>810 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 7 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *James Hill*

Licensed Embalmer No. 356

P. O. Address 38400

**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.