DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 14 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11823 STATE FILE NUMBER 60-043757

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 50 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Lutheran Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3104 Cherokee Street — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First DIMITRE Middle G. Last JUGLOFF
4. DATE OF DEATH: Month Dec. Day 7 Year 1960
5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/13/1877
9. AGE (last birthday): 83
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): merchant
10b. KIND OF BUSINESS OR INDUSTRY: retail liquor
11. BIRTHPLACE (City and state or country): Vom Bel, Macedonia
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: George Jugloff
13b. MOTHER'S MAIDEN NAME: Sophia Bioff
14. NAME OF HUSBAND OR WIFE: Stoina D. Nestoroff
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): – – – – –
16. SOCIAL SECURITY NO.: 492-24-3819
17. INFORMANT: Mrs. Anna Marie Siscel, Address: 4310 Blow (16)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage causing — INTERVAL BETWEEN ONSET AND DEATH: 10/11/60 to 12/7/60
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hemiplegia
DUE TO (c): 331x
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10/11/60 to 12/7/60 and last saw her him alive on 12/6/60
Death occurred at 1:10 A. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Ralph Berg MD (Degree or Title)
22b. ADDRESS: 3038 Grand
22c. DATE SIGNED: 12/8/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: Dec.10,1960
23c. NAME OF CEMETERY OR CREMATORY: St.Matthew Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS: BEIDERWIEDEN F.H.INC.,1936 St.Louis Ave.
25. DATE RECD. BY LOCAL REG.: DEC 9 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

Dr. Ralph Berg
3203 So. Grand

11:30 to 3:30 PM Wed

11:30 to 6 PM Thu.

No Friday

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp
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.