

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 Days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5510a Beacon Avenue, 20,
3. NAME OF DECEASED (Type or print) First PANAGOS Middle Last		4. DATE OF DEATH Month 11/ Day 6 Year 60	
5. SEX MALE	COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/29/92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenanceman		10b. KIND OF BUSINESS OR INDUSTRY Fouke Fur Co.	11. BIRTHPLACE (City and state or country) GREECE
13a. FATHER'S NAME George Paganos		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Annabel Panagos
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. None	17. INFORMANT Annabel Paganos, 5510a Beacon Avenue,

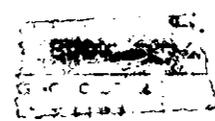
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial Infarction</u>	4201
	DUE TO (c) <u>H.C.V.D. (hypertensive cardiovascular disease)</u>	
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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year		
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 <u>Nov. 1958</u> to <u>11/6/60</u> and last saw her/him alive on <u>11/6/60</u> Death occurred at <u>2-25 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>David M. Neer, M.D.</u>	22b. ADDRESS <u>5535 Delmar, St. Louis, Mo.</u>	22c. DATE SIGNED NOV 9 1960
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-9-60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		

24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., St. Louis, 15, Missouri.	25. DATE RECD. BY LOCAL REG. NOV 9 1960	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

1921 5 1 904 24 0310



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 John A. Minick

Licensed Embalmer No. 4186

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.