

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044537

FILED VS DEC 12 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3444 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST LOUIS</u>	Length of stay in 1b <u>DOA</u>	a. STATE <u>MO</u>	b. COUNTY <u>ST LOUIS</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		c. CITY OR TOWN <u>OVERLAND</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>ST LOUIS CO HOSPITAL</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9448 LACKLAND</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>HELEN</u>	Middle <u>POULOS</u>	Last <u>POULOS</u>	4. DATE OF DEATH	Month <u>11</u>	Day <u>27</u>	Year <u>60</u>
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5. SEX <u>FEMALE</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>9-11-1902</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>CORINTH GREECE</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>WILLIAM TZEKOS</u>	13b. MOTHER'S MAIDEN NAME <u>MARY KALAGERAS</u>	14. NAME OF HUSBAND OR WIFE <u>GUS POULOS</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>NONE</u>	17. INFORMANT <u>GUS POULOS</u>	Address <u>9448 LACKLAND</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:		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma from breast</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY	Hour _____	Month, Day, Year _____
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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	COUNTY	STATE
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21. I attended the deceased from 11/9/52 to death and last saw her/him alive on 11/28/60
Death occurred at 11 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert Davis M.D.</u>	(Degree or title)	22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>11/28/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-30-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FEE FEE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO. MO</u>
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24. FUNERAL DIRECTOR <u>EARL HILLEMANN</u>	ADDRESS <u>OVERLAND MO</u>	25. DATE RECD. BY LOCAL REG. <u>11-28-60</u>	26. REGISTRAR'S SIGNATURE <u>J. E. Murphy M.D.</u>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.