MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-031044
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8009

FILED SEP 6 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.
Length of stay in 1b: 26 yrs. 1 mo 4 days.

c. CITY OR TOWN St.Louis,
Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital
Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 4509 McMillan Ave.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: ANDY Middle: Last: POULOS

4. DATE OF DEATH Month: August Day: 26, Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 1-1-03

9. AGE (last birthday): 58 yrs.
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): formerly: Clerk

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Tripolas, Greece

12. CITIZEN OF WHAT COUNTRY: Unk

13a. FATHER'S NAME: George Poulos

13b. MOTHER'S MAIDEN NAME: Mary (Stamata)

14. NAME OF HUSBAND OR WIFE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT Address: St.Louis State Hospital Records

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) Bronchopneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Syphilitic aortic insufficiency
DUE TO (c) Cirrhosis of the liver 023 X

INTERVAL BETWEEN ONSET AND DEATH

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 7-22-35, to 8-26-61 and last saw ~~her~~ him alive on 8-26-61
Death occurred at 6:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Thomas Thale MD (Degree or title) Thomas Thale, M.D.

22b. ADDRESS 5400 Arsenal St.

22c. DATE SIGNED 8-27-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 8-29-61

23c. NAME OF CEMETERY OR CREMATORY St.Matthews Cemetery

23d. LOCATION (City, town, or county) St.Louis,Mo. (State)

24. FUNERAL DIRECTOR ADDRESS Albert H.Hoppe,Inc.,4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG. AUG 28 1961

26. REGISTRAR'S SIGNATURE Hoard Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

2 | 9-2

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jay W Wilkinson

Licensed Embalmer No. 3575

P. O. Address M Louis M

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.