

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047043

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11788** STATE FILE NUMBER

AMENDED

**FILED DEC 21 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 days</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Incarnate Word Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3519a Greer Ave</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>PETE VIATRAS</b>			4. DATE OF DEATH Month Day Year <b>December 16 1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</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>6/25/1894</b>	9. AGE (last birthday) <b>67 years</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candy Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	11. BIRTHPLACE (City and state or country) <b>Zante, Greece</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Not Known</b>		13b. MOTHER'S MAIDEN NAME <b>Not Known</b>		14. NAME OF HUSBAND OR WIFE <b>Christine Viatras</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. <b>_____</b>		17. INFORMANT Address <b>Victoria Viatras - 3519a Greer Ave.</b>		

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) <b>ACUTE CONGESTIVE FAILURE</b>		<b>5 days</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>4 MO</b>
DUE TO (c) <b>7200</b>		

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		
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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 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
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21. I attended the deceased from <b>1946</b> to <b>12/16/61</b> and last saw her <b>alive</b> on <b>12/15/61</b> Death occurred at <b>7:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>D. Michael M.D.</b>	22b. ADDRESS <b>812 Olive</b>	22c. DATE SIGNED <b>12/18/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Dec 19, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>BUCHHOLZ MORTUARY-5967 W. Florissant Ave</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 18 1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Welford H. Berchholz

Licensed Embalmer No. 4551

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.