

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. **791**  
Primary Registration District No. **1003**

File No. **35946**  
Registered No. **10810**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** *Antonio Pappas*

(a) Residence. No. *6220 Franklin St.* **9** Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Not known*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*abt 78* ✓ ✓

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. *Candy Maker*  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Island Chios*  
(STATE OR COUNTRY) *Greece.*

10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Not known*  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)  
(STATE OR COUNTRY)

14. INFORMANT *John J. Hurley*  
(Address) *1425 Pershing*

15. FILED *1929* *10/30* *1929* *10/30* *1929* *10/30*  
REGISTRAR *[Signature]*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct. 30,* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at *8:00* P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*9.36*  
*Phonix Myocarditis*  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *90/10*  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *J. W. Kerner M.D.*  
*11/1/29* (Address) *Dep. Coran*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Matthews* DATE OF BURIAL *11/5* 19 *29*

20. UNDERTAKER *Ziegenheim Bros.* ADDRESS *2621 Cherokee St.*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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11  
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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No.....  
 Township..... Primary Registration District No. 1003 Registered No. 10810  
 City St. Louis (No.....) St..... Ward.....

**2. FULL NAME**

Antonio Pappas  
 (a) Residence. No..... St..... Ward.....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX MC 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work..... (duration) .....yrs.....mos.....ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) .....yrs.....mos.....ds.  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14.

INFORMANT..... (Address)

15.

FILED

10 26 19

Ray C. Stanley  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 30 1929  
 17. No Physician in attendance  
 I HEREBY CERTIFY That I attended deceased from..... 19..... to..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kermer M.D.

105 1929 (Address) St. Louis

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B. Every item of information should be stated EXACTLY. PHYSICIANS should state the cause of DEATH in plain terms, so that it may be classified. Exact statement of OCCUPATION is required. REGISTARS SHALL NOT RECEIVE A FEE FOR DATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1929  
35946