

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

Do not use this space.

41042

**1. PLACE OF DEATH**

County.....  
Towship.....  
City.....

Registration District No. 791  
1002  
Primary Registration District No. 1002  
St. Babypist Hospital

File No. 41042  
Registered No. 11705  
St. Ward

**2. FULL NAME**

(a) Residence. No. 6439 Nashville St. 4 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
about 53 - - -

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Charge Packer  
(b) General nature of industry, business, or establishment in which employed (or employer) Schwabert & Tremagne  
(c) Name of employer

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

10. NAME OF FATHER George Alifandis

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

12. MAIDEN NAME OF MOTHER Sophi Unknown

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

14. INFORMANT Sophie Alifandis  
(Address) 6439 Nashville

15. FILED 120 15 1930  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 13, 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 13, 1930, and that I last saw him alive on Dec 12, 1930, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Duodenal Ulcer Perforated

CONTRIBUTORY (SECONDARY) Gastric Ulcers & Hysterical accident  
(duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 6439 Nashville  
IF NOT AT PLACE OF DEATH? Nashville  
DID AN OPERATION PRECEDE DEATH? No DATE OF.....  
WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms  
(Signed) John C. Broad, M. D.  
(Address) 2945 Traver Road

\*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 Dec 15 1930

28. UNDERTAKER J. Murrills Foss  
ADDRESS 1407 Market St

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

