

FILED AUG 28 1943

Registration District No. 217

Primary Registration District No. 3063

Registrar's No. 1903

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town CLAYTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community Non-resident
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1500 Chesnut
(If rural, give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
year 1943 hour 2:40 minute A. M.
21. I hereby certify that I attended the deceased from August 15
1943 to August 19 1943
that I last saw him alive on August 19 1943
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage Duration 4 days

Due to Hypertension ?
Due to

Other conditions
(Include pregnancy within 3 months of death)
Tinea Tarsis

Major findings:
Of operations
Of autopsy
8301

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature John Niedrumer (M. D. or other) M.D.
Address 601 S. Brentwood Date Signed 8-11

3. (a) PRINT FULL NAME Nicholas Arvanitis

3. (b) If veteran, name war ----- 3. (c) Social Security No. -----

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced, Single ?

6. (b) Name of husband or wife ----- 6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased About 1891 ?
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52? Unknown ? ? hr. min.

9. Birthplace Greece 6
(City, town, or county) (State or foreign country)

10. Usual occupation Watchman

11. Industry or business -----

12. Name Constantine Arvanitis

13. Birthplace Greece 6
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Greece 6
(City, town, or county) (State or foreign country)

16. (a) Informant Father Angelidas

(b) Address St. Nicholas Greek Church

17. (a) Burial (b) Date thereof 8/21/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd.

19. (a) AUG 23 1943 (b) C. L. McCarroll
(Date of local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

26
3

707

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Albert G. Hoff*
Licensed Embalmer No..... *2971*
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 this body is not embalmed, fact should be so stated above.