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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 9 1947  
#67891 318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19224  
Registrar's No. 1999

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.

(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis City Hospital—Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
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. 10 4156a Labadie Avenue.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME KATHLEEN PASMEZOGLU

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Evangelos Pasmезoglu 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased About 1875?  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

72? ? ? \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown Turkey  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Philip Koroupe

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

14. Maiden name Unknown

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

16. (a) Informant Mary Pasmезoglu

(b) Address 4156a Labadie Avenue

17. (a) Burial (b) Date thereof 5/20/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 4700 W. Washington Blvd.

19. (a) MAY 18 1947 (b) J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17th  
year 1947 hour 8:10 minute A M.

21. I hereby certify that I attended the deceased from 5/8/47  
21, 1947, to May 17th, 1947  
that I last saw her alive on May 17th, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive cardio  
vascular disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy None

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? \_\_\_\_\_

Signature [Signature] 1515 Lafayette 5/17/47  
(City or town) (County) (State) (Date signed)

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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**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..... *Blair H. Cadwell*.....

Licensed Embalmer No. *4077*.....

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.**