

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

FILED MAR 11 1948

Registration District No. 318

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town..... St. Louis, Mo.  
(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  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether  
 In this community..... Unk  
years, months or days)

3. (a) PRINT FULL NAME..... JOHN CHAIRRAS

3. (b) If veteran, name war..... Unk

3. (c) Social Security No. .... Unk

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: August 15th, ?  
(Month) (Day) (Year)

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

71? 6

hr. min.

9. Birthplace: Russia  
(City, town, or county) (State or foreign country)

10. Usual occupation..... Unk

11. Industry or business.....

12. Name..... Unk

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

14. Maiden name..... Unk

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

16. (a) Informant..... M. Renard  
 (b) Address..... St. Louis City Hospital.

17. (a) Anatomical Board (b) Date thereof: FEB 29 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Anatomical Board

18. (a) Signature of funeral director..... Rowland Mortuary Service  
 (b) Address..... 104 Manchester Ave.

19. (a) FEB 29 1948 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County..... occu

(c) City or town..... St. Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No. .... 615 Walnut 9  
Memorial 23 5  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 22nd  
 year 1948 hour 2 minute 50 A. M.

21. I hereby certify that I attended the deceased from 2/16/48  
 19..... to Feb. 22nd 19 48  
 that I last saw him alive on Feb. 22nd 19 48  
 and that death occurred on the date and hour stated above.

Immediate cause of death..... Pulmonary Tuberculosis 10 yrs.  
 Duration

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....

Of autopsy.....

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..... J. A. Hansen M.D.  
1515 Lafayette 2/24/48  
 Address..... Date signed.....

MAR 24 1948  
MAR 24 1948

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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.....

Licensed Embalmer No.....

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.**