

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6665**
Registrar's No. **1588**

FILED MAR 8 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY OR TOWN St. Louis, Missouri | | c. CITY OR TOWN Clayton | |
| c. LENGTH OF STAY (In this place) | | 4462 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital | | d. STREET ADDRESS (If rural, give location) 6439 Clayton Road., | |

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|-----------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------|--|--|
| 3. NAME OF DECEASED a. (First) Emmanuel Nicolaou b. (Middle) also known as c. (Last) Hatzi-Nicolaou | | | 4. DATE OF DEATH (Month) (Day) (Year) February 15, 1952 | | |
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|--------------------|-------------------------------|--------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|---------------------------|-------------------------|-------|-------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married | 8. DATE OF BIRTH March 14, 1890 | 9. AGE (In years last birthday) 61 | IF UNDER 1 YEAR Months | IF UNDER 2 WKS. Days | Hours | Mins. |
|--------------------|-------------------------------|--------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|---------------------------|-------------------------|-------|-------|

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|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer | 10b. KIND OF BUSINESS OR INDUSTRY Grocery | 11. BIRTHPLACE (State or foreign country) Isle of Rhodes, Greece | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Nicholas Nicolaou | 13b. MOTHER'S MAIDEN NAME Unavailbale | 14. NAME OF HUSBAND OR WIFE None |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. Nil | 17. INFORMANT'S SIGNATURE OR NAME Tom Pamvakas | ADDRESS 6439 Clayton Road., |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH ? |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of colon with carcinomatosis | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|-----------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION 7-7-51 | 19b. MAJOR FINDINGS OF OPERATION Amular tumor of sigmoid | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|-----------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------|

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|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|

| | | |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 153X |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------|

22. I hereby certify that I attended the deceased from **6-8-51**, to **2-15-52**, that I last saw the deceased alive on **2-15-1952**, and that death occurred at **7:50 a.m.**, from the causes and on the date stated above.

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|-------------------------------------------------|-------------------|----------------------------------------|------------------------------------|
| 23a. SIGNATURE Jerome J. Finnan, M.D. | (Degree or title) | 23b. ADDRESS 3720 Washington | 23c. DATE SIGNED 2-16-52 |
|-------------------------------------------------|-------------------|----------------------------------------|------------------------------------|

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|-------------------------------------------------------------|-----------------------------|------------------------------------|-----------------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 2-20-52 | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) New York City, N.Y. |
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|------------------------------------------------|-----------------------------------------------|------------------------------------------------------------|----------------------------------------|
| DATE REC'D BY LOCAL REG. FEB 19 1952 | REGISTRAR'S SIGNATURE Carl Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe | ADDRESS 4700 Washington Blvd |
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m 93 (Licensed Embalmer's Statement on Reverse Side)

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

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 Me

working under my personal supervision.

Student Embalmer No.

Signed

Elton H. Remelius

Signed.....
Student Embalmer

Licensed Embalmer No. 4283

P.O. Address St. Louis, Mo.

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.