

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34893

FILED NOV 15 1955

State File No. _____

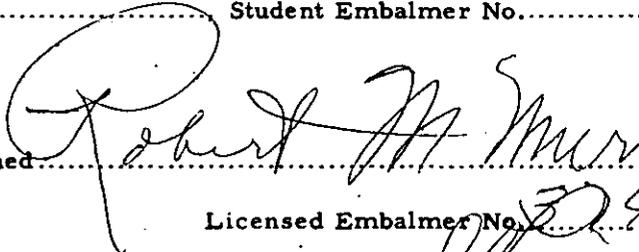
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|---|--|---|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>318</u> | | PRIMARY REG. DIST. NO. <u>1003</u> | | Registrar's No. <u>9441</u> | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis, Mo.</u> | | c. LENGTH OF STAY (In this place) _____ | | c. CITY OR TOWN <u>St. Louis,</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>4535 Durant Ave.</u> | | | | e. STREET ADDRESS (If rural, give location) <u>4535 Durant Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>James S. Kallaos</u> | | b. (Middle) <u>AKAS</u> | | c. (Last) <u>James S. Demitrios</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 27, 1955</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>Jan. 15, 1900</u> | |
| 9. AGE (In years last birthday) <u>55</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 12 Mths. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Grocer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Rhodes, Greece</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Sava Kallaos</u> | | 13b. MOTHER'S MAIDEN NAME <u>Kiriakoula Pipou</u> | | 14. NAME OF HUSBAND OR WIFE <u>Katholin Kallaos</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>496-36-1676</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Katholin Kallaos, 4535 Durant Ave.</u> | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary fibrillation</u> DUE TO (c) <u>Arteriosclerotic Ht Disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION <u>420.0</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 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? _____ | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 10, 1949</u> to <u>Death</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 17, 1955</u> , and that death occurred at <u>8:30 a.m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>Michael M. Karl</u> <u>Michael M. Karl</u> | | | | 23b. ADDRESS <u>4652 Maryland</u> <u>4652 Maryland</u> | | 23c. DATE SIGNED <u>10-29-55</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>10-31-55</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>OCT 29 1955</u> | | REGISTRAR'S SIGNATURE <u>Earl Smith MD</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington,</u> | | | |

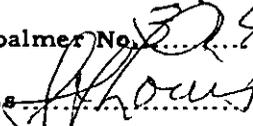
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 309

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.