FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25906

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6825

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: St.John's Hospital — Length of stay in Hospital: 8-days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits: Yes [X] No [ ]
STREET ADDRESS (If outside, give location): 5933 DeGiverville Ave. — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Alexander — Middle: — Last: Asadorian

4. DATE OF DEATH: Month July Day 21 Year 1957

5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: June 15,1871
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months 1 Days 6 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Orental Rug Salesman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Turkey
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Unknown Asadorian
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Marguerite Asadorian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr.Frank Lee, 722 Chestnut Street — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Infarction of myocardium — 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Coronary Thrombosis — 10 days
DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Duodenal Ulcer

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from 7-12-1957, to 7-21-57 and last saw ~~he~~ him alive on 7-20-57
Death occurred at 8:40 am. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Sylvester A. Featte (Degree or title) M.D.
22b. ADDRESS: 18 So. Kingshighway
22c. DATE SIGNED: 7-22-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 23,1957
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): Nokomis, Ill.

24. FUNERAL DIRECTOR: Arthur J. Donnelly — ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: JUL 22 57
26. REGISTRAR'S SIGNATURE: J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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~~ ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 4699

P. O. Address 3840 Lunde

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.