

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003525

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

244

300
-57
6
31

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp		Length of stay in 1b 50 yrs.	d. STREET ADDRESS (If outside, give location) 1605 So. Jefferson
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) MENAS SOTIROPOULOS (AKA) MENAS SOTIRIOU (AKA) SAM PETE MENAS		Middle	4. DATE OF DEATH Month Jan Day 7 Year 1959
---	--	--------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1885	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-----------------------	----------------------------------	---	--	--	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of work life, if any (if retired, state date of retirement)) Retired - Self Employed	10b. KIND OF BUSINESS OR INDUSTRY Restaurant & Candy Store	11. BIRTHPLACE (City and state or country) Kastoria, Greece	12. CITIZEN OF WHAT COUNTRY? U.S.
--	--	---	---

13a. FATHER'S NAME Unknown Sotiropoulos	13b. MOTHER'S MAIDEN NAME Sonia Unknown	14. NAME OF HUSBAND OR WIFE Sophia Sotiropoulos
---	---	---

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. 492-01-3278A	17. INFORMANT Address Sophia Sotiropoulos, 1605 So. Jefferson
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) 600.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	--	------------------------------	--------	-------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	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 Death occurred at 6:10 P 12/31/58 to 1/7/59 and last saw him alive on 1/7/59 m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE John M. Burns, M.D. (Degree or title)	22b. ADDRESS 1515 Lafayette	22c. DATE SIGNED 1/7/59
--	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-9-59	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	----------------------------	--	--

24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. JAN 8 '59	26. REGISTRAR'S SIGNATURE Paul Smith MD
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William L. Keneper*

Licensed Embalmer No. *4053*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.