

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013084

FILED VS MAR 17 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2635** STATE FILE NUMBER

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		Length of stay in 1b 52 yrs.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Lim. s Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4719 Washington Blvd.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALEX Middle NMN Last POULOS			4. DATE OF DEATH Month MARCH Day 4 Year 1960				
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 6/25/1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Owner			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kokova, Kalvarita, Greece	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME John Athanaso Puolos			13b. MOTHER'S MAIDEN NAME Catherine Sotoropoulos		14. NAME OF HUSBAND OR WIFE Ethel Paulos		
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. 492-30-4797	17. INFORMANT Ethel Paulos, 4719 Washington Blvd. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POST-OPERATIVE MASSIVE ABDOMINAL HEMORRHAGE						INTERVAL BETWEEN ONSET AND DEATH 5 HOURS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) BLOOD COAGULATION DEFECT						5 HOURS	
DUE TO (c) 154x							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ADENOCARCINOMA OF RECTUM					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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. _____ Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 3/28/60 to 3/5/60 and last saw her/him alive on 3/4/60 Death occurred at 11 45⁺ pm on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) C Alan McAfee M.D.				22b. ADDRESS 1000 Euclid St. Louis		22c. DATE SIGNED 3/5/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-7-60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.			
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. MAR 7 1960		26. REGISTRAR'S SIGNATURE Carl Smith, M.D. <i>mjr</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed (by _____) or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

W. W. [Signature]

Licensed Embalmer No. 35

P. O. Address 11 [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.