

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048356

FILED VS JAN 9 1961

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3667

1. PLACE OF DEATH a. COUNTY <b>St Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch, Mo</b>		c. CITY OR TOWN <b>Liberty Hotel 20th, &amp; Franklin St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robt. Koch Hospital</b>		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b <b>13 Days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <b>MIKE</b> First <b>PAPPAS</b> Middle <b>-</b> Last	4. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1960</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-12-83</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Greece</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A ?</b>
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13a. FATHER'S NAME <b>Dimetrius Pappas</b>	13b. MOTHER'S MAIDEN NAME <b>Algeria ?</b>	14. NAME OF HUSBAND OR WIFE <b>Nil</b>
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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) <b>??</b>	16. SOCIAL SECURITY NO. <b>??</b>	17. INFORMANT Address <b>Medical Records Koch Hospital</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease and or Fracture</b>	<b>??</b>
	DUE TO (c) <b>Fracture of Right Femur Nov 1960</b>	<b>1 month</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diverticula of Bladder with Neurogenic Bladder</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Pt fell at home &amp; suffered Rt. I.T. Fr.</b>
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20c. TIME OF INJURY Hour <b>3 S</b> Month, Day, Year <b>11-22-60</b>	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.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>	COUNTY	STATE
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21. I attended the deceased from <b>12-5-60</b> to <b>12-18-60</b> and last saw her/him alive on <b>12-18-60</b> Death occurred at <b>4:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Howard J. Suerel</i> M.D.	22b. ADDRESS <b>Koch Hospital Koch, Mo</b>	22c. DATE SIGNED <b>12-18-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12-20-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>12-20-60</b>	26. REGISTRAR'S SIGNATURE <i>John B. Murphy</i>
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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 G. W. Wilkinson

Licensed Embalmer No. 351

Address W. Lou

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.