

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022515

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1452

<b>FILED JUN 5 1963</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Louis</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>Richmond Heights</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>	d. STREET ADDRESS (If outside, give location) <b>4135a S. Grand</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Eftalia</b> Middle <b>Doias</b> Last	
4. DATE OF DEATH <b>May 2, 1963</b> Month <b>May</b> Day <b>2</b> Year <b>1963</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/1900</b>
9. AGE (last birthday) <b>63</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) <b>Albania</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Pete Petro</b>	13b. MOTHER'S MAIDEN NAME <b>Nunka Unk</b>
14. NAME OF HUSBAND OR WIFE <b>Naum Doias</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>	
17. INFORMANT <b>St. Louis, Mo. Naum Doias 4135a S. Grand</b>	
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>Coronary artery disease with grossly dilated vessels</b> DUE TO (b) <b>170x</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>Nov 61</b> to <b>death</b> and last saw her <b>alive</b> on <b>5-1-63</b> Death occurred at <b>8 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Charles R. Doyle MD</b>	22b. ADDRESS <b>654 N. Grand</b>
22c. DATE SIGNED <b>5/3/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>5-6-63</b>
23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cem.</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Southern Funeral Home</b> <b>6322 S. Grand, St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-3-63</b>
26. REGISTRAR'S SIGNATURE <b>John B. Mumfry MD</b>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

1 **4005**

2 **2159**

3

4 **1**

5 **1**

6

7 **2**

8 **2**

9 **170x**

10

11

12 **46-0**

13

**46**

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON



FORM NO. 1012 (10-1-57)

Mr. Char Doyle  
634 N Grand (304)  
30 to 430  
(County)

~~John Carter~~  
Mrs Davis

**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 Howard May Fossan

Licensed Embalmer No. 4542

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.