

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033658

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8257 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 22 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Richmond Heights	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital		d. STREET ADDRESS (If outside, give location) 7727 Brookline	
3. NAME OF DECEASED (Type or print) First Middle Last Apostolos N. Georgopoulos (AKA) Apostolos George		4. DATE OF DEATH Month Day Year August 12, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (City and state or country) Levithion, Arcadia, Greece U.S.
13a. FATHER'S NAME Nicholas Georgopoulos		13b. MOTHER'S MAIDEN NAME Unavailable	14. NAME OF HUSBAND OR WIFE Helen Georgopoulos
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address John A. Georgopoulos, 7727 Brookline	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) _____ DUE TO (c) 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Begins Prostatic Hypertrophy			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 February 1963 to August 12, 1963 and last saw her alive on August 12, 1963 Death occurred at 1:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. J. Lewis, M.D.		22b. ADDRESS 3400 N. KINGS HIGHWAY	22c. DATE SIGNED 8/13/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-15-63	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. AUG 13 1963	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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 Melvin J. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Washington
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.

11-200M

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