

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

16710
Do not use this space.

REC'D JUN 12 1939

1. PLACE OF DEATH

(a) County..... Registration District No..... 791
(b) Township..... Primary Registration District No..... 1003
(c) City..... St. Louis..... (d) Street No. City Hospital No. 1..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

E. 510
2. PRINT FULL NAME *200* George Gog

(a) Residence, No. 1506 Montgomery *24* (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Adeline M. Gog.*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 14, 1886*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 8 23

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *City Hospital*
9. Industry or business in which work was done, as saw mill, bank, etc. *elevator man*
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

FATHER
13. NAME *George Gog*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

MOTHER
15. MAIDEN NAME *Kate Kelly*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

17. INFORMANT (ADDRESS) *Hosp. Info M. Kent*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Calvary Cem* DATE *May 8, 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *St. Reidner and Co
1417 W. Market Str.*

20. FILED *J. F. Brubaker*
MAY 8 1939 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5/7/39*, 19

22. I HEREBY CERTIFY That I attended deceased from *4/12/39* to *5/7/39*, 19
I last saw him live on *5/7/39*, 19. Death is said to have occurred on the date stated above, at *9.50 P.*
The principal cause of death and related causes of importance were as follows:
Coronary Occlusion
no. 1
Date of onset

Other contributory causes of importance: *[Signature]*

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) *William Sapsin*, M. D.
(Address) *City Hospital No. 1*

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John P. Buchholz

Licensed Embalmer No. *1474*

P. O. Address *2723 St. Louis Ave*

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 this body is not embalmed, above space should be left blank.