

FILED MAY 26 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 17593
4616
Registrar's No.

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Enroute to City Hospital #1. 3
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) unknown

3. (a) PRINT FULL NAME THOMAS GONGORA

3. (b) If veteran, name war Nil 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 16, 1893
(Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 29 If less than one day hr. min.

9. Birthplace Mexico 3
(City, town, or county) (State or foreign country)

10. Usual occupation Un-employed

11. Industry or business _____

12. Name Thomas Gongora 3

13. Birthplace Mexico 3
(City, town, or county) (State or foreign country)

14. Maiden name Delores Soaiz

15. Birthplace Mexico 3
(City, town, or county) (State or foreign country)

16. (a) Informant Anthony Gongora

(b) Address 1025 Frey Street

17. (a) burial (b) Date thereof 5-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) MAY 18 1948 (Date received local registrar) J. F. Bresnahan (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1025 Frey Street
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15th year 1948 hour _____ minute 30 P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation of Brown
Salmonella Cholerae
Alcoholism
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature Dr. J. F. Bresnahan (M. D. or other) 5/18/48
 Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2
5
39
47070

C O R O N E R

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..... *R R Cooper*

Licensed Embalmer No. *3663*

P. O. Address. *2301 Lafayette*

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, fact should be so stated above.