

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38011

Registration District No. 791

Primary Registration District No.

Registrar's No. 9850

1. PLACE OF DEATH:

(a) County 2
 (b) City or town ST LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
6915 PENNSYLVANIA A.Y.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 30 YRS
 (Specify whether
 In this community 5 YRS
 years, months or days)

8. (a) PRINT FULL NAME LOUIS MANUEL GONZALES8. (b) If veteran, name war no 8. (c) Social Security No. 589-09-96394. Sex MALE 5. Color or race white 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife MARIA 6. (c) Age of husband or wife if7. Birth date of deceased JUNE 30 1886
(Month) (Day) (Year)8. AGE: Years 53 Months 4 Days 18 If less than one day
hr. min.9. Birthplace SPAIN
(City, town, or county) (State or foreign country)10. Usual occupation CHEF11. Industry or business HOTEL12. Name JACINTO GONZALES13. Birthplace SPAIN
(City, town, or county) (State or foreign country)14. Maiden name FRANZISKA SORRES15. Birthplace SPAIN
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Maria Gonzales(b) Address 6915 Pennsylvania17. (a) BURIAL (b) Date thereof Nov 20-39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation MNT HOPE CEM18. (a) Signature of funeral director J. P. Frank(b) Address 712 S. Washington19. (a) NOV 19 1939 (b) J. P. Frank
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 1
 (c) City or town ST LOUIS
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6915 PENNSYLVANIA A.Y.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 30 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17th
year 1939 hour 9 minute M.21. I hereby certify that I attended the deceased from Nov 1937
to Nov 17 1939
that I last saw him alive on Nov 17 1939
and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma of prostate
and bladder urinaryDue to Primary site unknown

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 51

Of autopsy

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) (e) Means of injury

23. Signature Charles Ehlers (M. D. or other)
Address 7201 S. Broadway Date signed 11-18-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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..... *Joseph P. Fendler Jr*

Licensed Embalmer No. *925*

P. O. Address..... *St Louis*

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.