

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 CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 34203
8900
Registrar's No.

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis Mo
(b) City or town St. Louis
(c) Name of hospital or institution 5124 Labadie
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

John Gough

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 5. Color of race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret Gough 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 28 1891 (Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Traffic Mgr

11. Industry or business

MOTHER FATHER { 12. Name John Gough
13. Birthplace Mo (City, town, or county) (State or foreign country)
14. Maiden name Mary Wadsworth
15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Gough
(b) Address 5124 Labadie
17. (a) Burial (b) Date thereof 10/30/40 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Dullman
(b) Address 2849 No. Euclid

19. (a) OCT 29 1940 (Date received local registrar) (b) J. Bradish (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 5124 Labadie (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28
year 1940 hour 4:5 minute P.M.

21. I hereby certify that I attended the deceased from September 28 to October 28, 1940, that I last saw him alive on October 27, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 5 mo
Due to 7 3
Due to 7 3
Other conditions Internal Hypertension 177
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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 P. S. Henge (Name of physician)
Address 462 No. Taylor Date signed 10/28/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.