No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 8 #45391 318

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

Primary Registration District No.

State File No. 29051

Registrar's No.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital #1. 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 8042

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2723 RUTGER 9
(If rural, give location)

(e) Citizen of foreign country? 22 (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME JOHN GARGONJA

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, married, widowed, divorced WIDOWER

6. (b) Name of husband or wife ANNA

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

7. Birth date of deceased MAY (Month) 16 (Day) 1867 (Year)

8. AGE: Years	Months	Days	If less than one day
80	2	29	hr. min.

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

10. Usual occupation U.K.

11. Industry or business

FATHER
12. Name TONY GARGONJA 8
13. Birthplace YOGASLAVIA (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARY U.K. 9
15. Birthplace U.K. (City, town, or county) (State or foreign country)

16. (a) Informant MISS BURREN.
(b) Address 2335 MULLANPHY

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-25-47 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen-Kelly
(b) Address 4386 Lindell

19. (a) AUG 25 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15th year 1947 hour 4:05 minute A M.

21. I hereby certify that I attended the deceased from 7/26/47 19 to Aug. 15th 1947 that I last saw him alive on Aug. 15th 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Septicemia due to E. Coli	3 wks
Due to Multiple liver abscesses - cause not known	
Due to Cholelithiasis with stone in common duct	6 wks
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations No
Of autopsy 0

PHYSICIAN — Underline the cause of 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? (Specify type of place) 0
While at work? (Specify type of injury)

23. Signature K. D. [illegible] (M. D. or other) 8/15/47
Address 1515 Lafayette Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Howard T Rowland

Licensed Embalmer No. 3114

P. O. Address 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 this body is not embalmed, fact should be so stated above.