

LOUISIANA STATE DEPARTMENT OF HEALTH AND
THE CITY OF NEW ORLEANS DEPT. OF HEALTH

License No. _____

Certificate of Marriage

State of Louisiana

Parish of Orleans

This is to certify that I Mrs. Gerard L. Frey, a Priest
of the Catholic Church, by virtue of the license required by law did
on this 20th day of February, 1960, A.D., unite in

Holy Bonds of Matrimony

Paul F Bourg
Groom

Sandra Campora
Bride

In testimony whereof I have caused the said parties with myself and three legal Witnesses,
to sign these presents, the day and date aforesaid.

Witnesses:

Parties:

Joy Ann Girvin
Signature of Witness

Paul F Bourg
Signature of Groom

Rudolph J Campora
Signature of Witness

Sandra Campora
Signature of Bride

Charles M. Mc Guinness
Signature of Witness

Mrs. Gerard L. Frey
Signature of Officiant (Priest, Minister, other)

To Be Given to Bride and Groom

LACO 1-20

MISSISSIPPI STATE DEPARTMENT OF HEALTH
VITAL RECORDS



10112030

2011-021586

FILING DATE OCT 18 2011

CERTIFICATE OF DEATH
STATE OF MISSISSIPPI

STATE FILE NUMBER 123-

| | | | | | |
|---|--|---|---|---|---|
| 1. NAME First Middle Last PAUL FELIX BOURG | | | 2. SEX M | 3a. HOUR OF DEATH 04:28 A. m. | 3b. DATE OF DEATH (Month, Day, Year) OCTOBER 2, 2011 |
| 4. RACE (Specify White, Black, American Indian, etc.) White | 5a. AGE AT LAST BIRTHDAY 73 Years | ONLY IF UNDER 1 YEAR 5b. MOS 5c. DAYS | ONLY IF UNDER 1 DAY 5d. HOURS 5e. MINS | 6. DATE OF BIRTH (Month, Day, Year) July 12, 1938 | 7. STATE OF BIRTH LA |
| 8. PLACE OF DEATH (Check only one box) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | IF DEATH OCCURRED IN A HOSPITAL | | | |
| 9a. FACILITY NAME (If not a facility, give street address, route number, or other location) MEMORIAL HOSPITAL AT GULFPORT #24M | | 9b. CITY, TOWN OR LOCATION OF DEATH GULFPORT | | 9c. COUNTY OF DEATH HARRISON | |
| 10. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/High School (0-12) College (1-4, 5-6) 3 | 11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 12. SURVIVING SPOUSE (If wife, give maiden name) Sandra Campora | | 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) Yes |
| 14. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify) | 15. SOCIAL SECURITY NUMBER 439-56-8264 | | 16a. USUAL OCCUPATION (Kind of work done most of working life) Air Traffic Controller | | 16b. KIND OF BUSINESS OR INDUSTRY Airline |
| 17a. RESIDENCE - STATE MS | 17b. COUNTY Harrison | 17c. CITY OR TOWN Gulfport | 17d. INSIDE CITY LIMITS (Specify Yes or No) Yes | 17e. STREET AND NUMBER OR RURAL LOCATION 395 Grubbs Ave. | |
| 18. FATHER - NAME First Middle Last Paul Gabriel Bourg | | | 19. MOTHER - NAME First Middle Maiden Mary Trainor | | |
| 20a. INFORMANT - NAME (Type or print) Sandra Campora Bourg | | 20b. RELATIONSHIP TO DECEDENT Wife | | 20c. MAILING ADDRESS (Street and number, City or town, State, ZIP Code) 395 Grubbs Ave. Gulfport, MS 39507 | |
| 21a. DISPOSITION OF BODY (Specify Burial, Cremation, Removal, etc.) Cremation | | 21b. CEMETERY/CREMATORY - NAME Biloxi National Cemetery | | 21c. LOCATION (City and State) Biloxi, MS | |
| 22b. FUNERAL HOME - NAME Marshall Funeral Home 24F | | 22c. FUNERAL HOME LICENSE NUMBER FE494 | | 22d. MAILING ADDRESS (Street and number, City or town, State, ZIP Code) 825 Division Street Biloxi, MS 39530 | |
| 23a. PERSON WHO PRONOUNCED DEATH - NAME AND TITLE (Type or print) CYRIL BETHALA, M.D. | | | 23b. PRONOUNCED DEAD (Month, Day, Year) OCTOBER 2, 2011 | | 23c. PRONOUNCED DEAD (Hour) AT 04:28 A. m. |
| 24a. CERTIFIER - NAME (Type or print) CHARLES WISE | | 24b. MAILING ADDRESS (Street and number, City or town, State, ZIP Code) P.O. BOX 4036, GULFPORT, MS 39502 | | | |
| This section to be completed by Physician if NOT a medical examiner | 25a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated. SIGNATURE > _____ MD | | This section to be completed by coroner or medical examiner ONLY | 25e. On the basis of examination and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated. SIGNATURE > _____ | |
| | 25b. DATE SIGNED (Month, Day, Year) | 25c. STATE LICENSE NUMBER | | 25f. TITLE HARRISON COUNTY DEPUTY CORONER | |
| | 25d. NAME OF ATTENDING PHYSICIAN (If other than certifier) (Type or Print) | | | 25g. DATE SIGNED (Month, Day, Year) OCTOBER 3, 2011 | |
| 26. PART I - Enter the chain of events, diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS. | | | | | |
| IMMEDIATE CAUSE (final disease or condition resulting in death) | | CARDIOGENIC SHOCK | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST. | | (a) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): OCCLUSION OF THE CORONARY ARTERIES | | | |
| | | (b) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): CORONARY ARTERY DISEASE | | | |
| | | (c) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): | | | |
| | | (d) | | | |
| 27. PART II: OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I. | | | | | |
| 30. IF FEMALE, SPECIFY: <input type="checkbox"/> Was not pregnant within the past year <input type="checkbox"/> Was pregnant at the time of death <input type="checkbox"/> Not pregnant, but had been pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year | | | | 32. AUTOPSY (Yes or No) NO | |
| 31a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify) | | 31b. DATE OF INJURY (Month, Day, Year) | | 31c. HOUR OF INJURY m. | |
| 31d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED | | 31e. INJURY AT WORK (Yes or No) | | | |
| 31f. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.) | | 31g. LOCATION Street or route number | | City or town State | |

Mississippi State Department of Health

Revised 1-4-08

Form 511

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE.

10/24/2011

Judy Moulder

Judy Moulder
STATE REGISTRAR

WARNING: A REPRODUCTION OF THIS DOCUMENT RENDERS IT VOID AND INVALID. DO NOT ACCEPT UNLESS EMBOSSED SEAL OF THE MISSISSIPPI STATE BOARD OF HEALTH IS PRESENT. IT IS ILLEGAL TO ALTER OR COUNTERFEIT THIS DOCUMENT.

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE



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