The Commonwealth of Massachusetts

STANDARD CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

REGISTERED NUMBER: 06540

STATE USE ONLY

1. DECEDENT NAME FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Mo. Day Yr.)
Mauricio		Gaston	Male	September 13,1986

4a. PLACE OF DEATH (CITY OR TOWN)	4b. COUNTY OF DEATH	4c. HOSPITAL OR OTHER INSTITUTION Name (If not in either give street and number)	4d. IF IN HOSPITAL DOA (Yes or No)
Boston	Suffolk	Beth Israel Hospital	No

5. RACE (e.g. White Black American Indian etc.) (Specify)	6a. AGE Last Birthday (Yrs.)	UNDER 1 YEAR: 6b. MOS / DAYS	UNDER 1 DAY: 6c. HOURS / MINS	7. DATE OF BIRTH (Mo Day Yr.)	8. STATE OF BIRTH (If not in U.S.A. name country)
White	39			Sept. 10, 1947	Cuba

9. MARRIED NEVER MARRIED WIDOWED OR DIVORCED	10. SPOUSE (If wife give maiden name)	11a. USUAL OCCUPATION (Prior if Retired)	11b. KIND OF BUSINESS OR INDUSTRY
Married	Miren Uriate	Professor	Education

12. SOCIAL SECURITY NUMBER	13. IF U.S. WAR VETERAN SPECIFY WAR	14. RESIDENCE - STREET AND NUMBER CITY OR TOWN COUNTY STATE ZIP CODE
258-76-5897	-----	60 Union Ave., Boston, Suffolk Co.,MA 02130

15a. FATHER FULL NAME	15b. STATE OF BIRTH (If not in U.S.A. name country)	16a. MOTHER NAME (GIVEN) MAIDEN	16b. STATE OF BIRTH (If not in U.S.A. name country)
Miguel Gaston	Cuba	Margarita Roche	Mexico

17a. INFORMANT NAME AND ADDRESS	17b. RELATIONSHIP
Miren Uriarte-Gaston,60 Union Ave.Boston, MA 02130	Wife

18a. TYPE OF DISPOSITION (Specify Burial Cremation, Other)	18b. DATE OF DISPOSITION	18c. PLACE OF DISPOSITION AND LOCATION CITY OR TOWN STATE
Cremation	Sept 15,1986	Forest Hills Crematory, Boston, MA

19a. FUNERAL SERVICE LICENSEE	19b. NAME OF FACILITY	19c. ADDRESS OF FACILITY
Charles F. Scott	J.S.Waterman & Sons	495 Comm. Ave. Boston Mass

20. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) (PRINT OR TYPE LEGIBLY)

PART I

		Interval between onset and death
20a.	Respiratory Failure	Hours
DUE TO OR AS A CONSEQUENCE OF		
20b.	Pneumocystis Carinii Pneumonia	Days
DUE TO OR AS A CONSEQUENCE OF		
20c.	Acquired Immune Deficiency Syndrome	Days

PART II — OTHER SIGNIFICANT CONDITIONS Conditions contributing to death but not related to cause given

21. AUTOPSY (Yes or No)	22. WAS CASE REFERRED TO MED EXAM Yes or No.
No	No

23. ACC SUICIDE HOM UNDET OR PENDING INVEST (Specify)	24a. DATE OF INJURY (Mo Day Yr.)	24b. HOUR OF INJURY	24c. DESCRIBE ... INJURY OCCURRED

24d. INJURY AT WORK (Specify Yes or No)	24e. PLACE OF INJURY - At home farm street factory, office building etc. (Specify)	24f. LOCATION STREET	CITY OR TOWN STATE

To be Completed by CERTIFYING PHYSICIAN Only

25a. To the best of my knowledge death occurred at the time date and place and due to the cause(s) stated

(Signature and Title) Michael D. Damiano M.D.

25b. DATE SIGNED (Mo Day Yr.)	25c. HOUR OF DEATH
September 13,1986	9:32 P.M.

25d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
John Jainchill,M.d.

To be Completed by MEDICAL EXAMINER Only

26a. On the basis of examination and/or investigation in my opinion death occurred at the time date and place and due to the cause(s) stated

(Signature and Title)

26b. DATE SIGNED (Mo. Day Yr.)	26c. HOUR OF DEATH

26d. PRONOUNCED DEAD (Mo Day Yr.) ON	26e. PRONOUNCED DEAD (Hour) AT

27. NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print)
Micheal Damiano,M.d. Beth Israel Hospital 330 Brookline Ave Boston, MA 02215

28. BURIAL PERMIT ISSUED ON	DATE	29. RECEIVED IN THE CITY OR TOWN OF	DATE RECEIVED
11 34155	September 14 1986	BOSTON	SEP 16 1986
SIGNATURE-BD HEALTH AGT		CLERK'S SIGNATURE Judith A. McCarthy	