

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

21428
File No. _____
Registered No. **6305**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)

2. FULL NAME

(a) Residence. No. **1911 09** St. **23** Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **70** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male**
4. COLOR OR RACE **white**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 14 1859**
7. AGE YEARS **70** MONTHS **8** DAYS **14**
If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Painter**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Morris**
10. NAME OF FATHER **And. Vogt Sr**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
12. MAIDEN NAME OF MOTHER **Katherine Dehaube**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT (Address) **City Hospital**
15. FILED **6611 29 1930** **19** **Wm C Stanley** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 28 1930**
17. I HEREBY CERTIFY, That I attended deceased from June 23 1930 to June 28 1930 that I last saw him alive on June 25 1930 and that death occurred, on the date stated above, at 1:45 p. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93C Terminal
111B Congestion of Lungs
(duration) _____ yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **911B**
(duration) _____ yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
19. DID AN OPERATION PRECEDE DEATH **No** DATE OF _____
20. WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS **Clinical**
(Signed) **Carl H. Hoff** M. D.
129. 130 (Address) **City Hospital**
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St. Johns. North** **DATE OF BURIAL** **July 1 1930**
20. UNDERTAKER **Wm F Paschedag** **ADDRESS** **2825 No 21st**

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Voght.