

No. 2  
-2-43  
-17-39  
X35697

FILED **SEP 18 1945**

Primary Registration District No. **1003**

Registrar's No. **8063**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
St. Louis City Hospital. 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 3716 Grandel Square. 9  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Hermann Vogt.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M. ( ) 5. Color or race W. 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Dont Know. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 4, 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>0</u>	<u>11</u>	hr. _____ min.

9. Birthplace Sweden. 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Dont Know.

11. Industry or business \_\_\_\_\_

12. Name Dont Know.

13. Birthplace Dont Know. 4  
(City, town, or county) (State or foreign country)

14. Maiden name Dont Know.

15. Birthplace \_\_\_\_\_ 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Rev. James R. O'Neill S.J.

(b) Address 3628 Lindell Blvd.

17. (a) Burial. (b) Date thereof 9-17-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) SEP 15 1945 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15th.  
year 1945 hour 12, minute 30 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above:

Immediate cause of death Thrombotic Myocardial Infarction

Self administered at his home

at 3716 Grandel Square on

Sept. 13, 1945 - at about 3:00 P.M.

while suffering from temporary

renal arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 1638.2

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence 9/13/1945

(c) Where did injury occur? at home  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

23. Signature Patrick E. Taylor (M: D: or other) 3  
Address Key Co Date signed 9/15/45

PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Oct  
Registrar's No. 8063

Registration District No. 314 Primary Registration District No. 1003

WRITE PLAINLY—USE INK—READING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(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 Hermann Vogt  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced..... wid  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
 7. Birth date of deceased Sept 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70.....hr.....min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER } 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) OCT 1 1945 J. F. Bredek  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits, write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....  
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....  
 Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to 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?.....

While at work?.....  
(Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

1945  
S-29452

70071 \* (unclear)