

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

**FILED DEC 31 1945**

1003

Registrar's No. **10166**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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:  
Deaconess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day 1 Hour  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County aaa  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 2317  
(d) Street No. 1622 Dolman  
(If rural, give location) 9  
(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Henry Vogler

3. (b) If veteran, name war No 3. (c) Social Security No. 498-05-2945

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fairy 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Sept. 27 1889  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 1 24 hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Inspector

11. Industry or business City Water Division

12. Name Frank Henry Vogler Sr.

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

14. Maiden name Minnie Hoffmeister

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

16. (a) Informant Fairy Vogler  
(b) Address 1622 Dolman

17. (a) Burial (b) Date thereof 11 / 24 / 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) NOV 24 1945 (b) J. Z. Braeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 21  
year 45 hour 12:00pm minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from November  
20, 1945, to Nov. 21, 1945  
that I last saw him alive on Nov. 21, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Progressive Asthma  
Empyema

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Empyema, Asthma  
Chronic Hyperostosis (osteitis)

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 Wilbert G. Smith (M. D. or other) \_\_\_\_\_  
Address 150 Oakwood Date signed 11/24/45

Duration

3-4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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 *L. R. Cooper*

Licensed Embalmer No. *2633*

P. O. Address *2317 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.**