

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35158**
8718

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		d. STREET ADDRESS (If rural, give location) 3834 St. Louis Ave	

3. NAME OF DECEASED (Type or Print)	a. (First) Mery	b. (Middle)	c. (Last) Gogel	4. DATE OF DEATH (Month) (Day) (Year) Oct 9th, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 2nd 1874	9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 28 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work; None during most of working life, even if retired) Housework	10b. KIND OF BUSINESS, OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S. A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Henry A. Gogel
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Anthony Gogel	ADDRESS 3663 Leirman
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 30 Min.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Uremia DUE TO (c) Hypertensive Cardio-Vasc Dis.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Nephritis		334X	

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 93rd
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H2S
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22. I hereby certify that I attended the deceased from **10-7-1949**, to **10-9-1949** that I last saw the deceased alive on **10-9-1949**, and that death occurred at **7:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Anthony Vitale MD	23b. ADDRESS 3861 St. Louis Ave.	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 12 49	24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 10 1949	25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Bros	ADDRESS 2849 N Euclid
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Robert L. Brinkman*
Licensed Embalmer No. 3553

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.