

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25873

State File No.

FILED AUG 11 1954

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>1688</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lemay</u>		c. LENGTH OF STAY (in this place) <u>2 months</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lemay Nursing Home</u>				e. STREET ADDRESS (If rural, give location) <u>3684 Dover</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Gustave</u>			b. (Middle) <u>G.</u>		c. (Last) <u>Voerg</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 13, 1954</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 21, 1878</u>		9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 YEAR Hours _____	IF UNDER 1 YEAR Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Disinfectant Co.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>August Voerg</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Bauer</u>		14. NAME OF HUSBAND OR WIFE <u>Helen E. Voerg</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>486-22-2648A</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Helen E. Voerg, 3684 Dover</u>					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>10 yrs</u>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4200</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>6/4</u> , 19 <u>54</u> , to <u>7/13</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>7/13</u> , 19 <u>54</u> , and that death occurred at <u>9:15 Pm.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Mitchell L. Barbuch</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>7629 So. Broadway</u>		23c. DATE SIGNED <u>7/14/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 16, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri.</u>				
DATE REC'D BY LOCAL REG. <u>7/14/54</u>		REGISTRAR'S SIGNATURE <u>Respected</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>6464 C. Hoffmeister Colonial Mortuary, Chippewa.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. M. L. Bartnick,
7629a S. Broadway, 11

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.....
Signature of Student Embalmer

Signed *Linus C. Hoffmeister*.....

Licensed Embalmer No. 3871

P. O. Address 7814 S.B.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.