

FILED AUG 2-1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24499**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5451**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		STREET ADDRESS (If rural, give location) <b>5301 Page Blvd.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Marie</b>	b. (Middle) <b>Agnes</b>	c. (Last) <b>Vogel</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 21, 1955</b>
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5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>S.</b>	8. DATE OF BIRTH <b>Aug. 14, 1895</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Record Room, St. Ann's Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Louis Vogel</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Donican</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>499-34-1858</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Sister Jane Francis, 5301 Page Blvd.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Congestion</b>	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Car Pulmonary; Fracture of right hip; Hypostasis of spine; suffered when deceased fell out of bed at City Hospital on June 21, 1955</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>exact time unknown</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Aspt</b>	21c. (CITY, TOWN, OR TOWNSHIP) COUNTY STATE <b>St. Louis Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>June 21 55? m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>E9027</b>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **10:35A.m.**, from the causes and on the date stated above. **45**

23a. SIGNATURE (Degree or title) <b>Robert E. Taylor, M.D.</b>	23b. ADDRESS <b>1300 Clark Ave</b>	23c. DATE SIGNED <b>6/23/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>June 24, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>JUN 23 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm J. Donnelly 3840 Lindell Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

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: *Francis Willbourn*

Licensed Embalmer No. *350*

P. O. Address *3840 Le...*

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.