

FILED SEP 8 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27673

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7458

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 1 year	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 4622 Carter Avenue		STREET ADDRESS (If rural, give location) 4622 Carter Avenue	

3. NAME OF DECEASED (Type or Print) Olga Foege			4. DATE OF DEATH (Month) (Day) (Year) August 23 1955		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH May 25 1878		9. AGE (In years last birthday) 77		10. IS RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Salem, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Conrad Buchhold		13b. MOTHER'S MAIDEN NAME Katherine Weber		14. NAME OF HUSBAND OR WIFE Fred H. Foege	
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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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred H. Foege, 4622 Carter A venue	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 1 week	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		DUE TO (b) Chronic valvular heart disease					
DUE TO (c) Arterio sclerosis		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 410X	
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22. I hereby certify that I attended the deceased from **8-19, 1955**, to **8-23, 1955**, that I last saw the deceased alive on **8-22, 1955** and that death occurred at **11:45 P.**, from the causes and on the date stated above.

23a. SIGNATURE John F. Foege (Degree or title) Phys.		23b. ADDRESS 4723 Carter Ave. St. Louis		23c. DATE SIGNED 8-25-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 26 1955		24c. NAME OF CEMETERY OR CREMATORY New Pickers Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Missouri	
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DATE REC'D BY LOCAL REG. AUG 25 1955		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Ave	
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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.....
Signature of Student Embalmer

Signed *Clement McNear*.....

Licensed Embalmer No. *379*

P. O. Address *St. Louis*

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.