

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046447

STATE FILE NUMBER

12107

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12107

FILED DEC 22 1958

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, give TOWNSHIP only) OR TOWN ST LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST LOUIS,
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 02 ALEXIAN HOSPITAL		Length of stay in 1b 1/57	d. STREET ADDRESS (If outside, give location) 3628 a MONTANA AVE
3. NAME OF DECEASED (Type or print) First J. Middle GREGORY Last VOGEL		4. DATE OF DEATH Month DEC, Day 13, Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT, 9, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY WARD BAKING CO.	9. AGE (In years last birthday) 53
11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME OTTO A. VOGEL		13b. MOTHER'S MAIDEN NAME LILLIAN ROSE FITZGERALD	14. NAME OF HUSBAND OR WIFE IRENE VOGEL
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. #	17. INFORMANT Address IRENE VOGEL 3628 a MONTANA AVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) arterio sclerosis pure DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 mo. ?
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from 11/17/1958 to 12-13-58 and last saw her/him alive on 12-12-58 Death occurred at 12 noon m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) H. Nachweyer M.D.	
22b. ADDRESS 406.5 S. Grand Ave		22c. DATE SIGNED 12/17/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/17/58	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI
24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE		25. DATE RECD. BY LOCAL REG. DEC 16 '58	26. REGISTRAR'S SIGNATURE Carl Smith M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

~~Dr. J. J. ...~~
Dr. J. J. ...
Mark ...
4065 to Grand.

Feb 24/34
3 pm

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 M. W. Rueter

Licensed Embalmer No. 4885
P. O. Address St. Louis, Mo

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.