

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 1 0 1959

59-026301

Registration District No. 310 Primary Registration District No. 308 Registrar's No. 187 STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <b>Saint Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural-St. Chas. twsp.</b>		Length of stay in lb <b>3 yrs</b>	c. CITY OR TOWN <b>Maplewood</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Emmaus Home</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7623 Weaver Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Frieda</b> Middle <b>Voges</b> Last <b>Voges</b>	4. DATE OF DEATH Month <b>Aug.</b> Day <b>5,</b> Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30, 1899</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min. <b>59</b>	IF UNDER 24 HR Hours <b>59</b> Min. <b>59</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own</b>	11. BIRTHPLACE (City and state or country) <b>Jackson, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Charles Voges</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Wettengel</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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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>None</b>	17. INFORMANT <b>Theophil Stoerker, St. Charles,</b> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b>
DUE TO (b) <b>Metastatic Carcinoma</b>		<b>1 month</b>
DUE TO (c) <b>Carcinoma of Colon</b>		<b>2 yr.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour <b>5:30</b> a.m. <b>PM</b> Month, Day, Year <b>Nov 1954</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St Charles, Mo</b> COUNTY <b>St Charles</b> STATE <b>Mo</b>
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21. I attended the deceased from **Nov 1954** to **August 1959** and last saw her **August 5, 1959** alive on **August 5, 1959**  
Death occurred at **5:30 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W M H Pogreemeier MD</b> (Degree or title)	22b. ADDRESS <b>St Charles, Mo</b>	22c. DATE SIGNED <b>Aug 6, 1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Aug. 6, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Evangelical</b>	23d. LOCATION (City, town, or county) (State) <b>Tilsit, Missouri</b>
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24. FUNERAL DIRECTOR <b>McCombs Funeral Home, Jackson, Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Aug 6 - 59</b>	26. REGISTRAR'S SIGNATURE <b>Maree Wilson</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Frank R. Amador*

Licensed Embalmer No. 489

P. O. Address M. Ch

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.