

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013338

FILED VS. MAR 3 1 1960

2 3126

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 5 Days | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3619 N. Newstead Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Grace Middle Last Vogt | 4. DATE OF DEATH Month 3 Day 16 Year 1960 |
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|-------------------------|----------------------------------|---|-----------------------------------|-------------------------------------|---|----------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6/8/78 | 9. AGE (last birthday) 81 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-------------------------|----------------------------------|---|-----------------------------------|-------------------------------------|---|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Office Clerk (ret.) | 10b. KIND OF BUSINESS OR INDUSTRY Office Work | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME William Vogt | 13b. MOTHER'S MAIDEN NAME Dora Wiechor | 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) No | 16. SOCIAL SECURITY NO. 490-22-6251A | 17. INFORMANT Address Emma Eilers, 1388 Union Blvd. |
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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) Cerebral arterial hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 5 days many years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) arteriosclerosis | |
| | DUE TO (c) 331x | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Biliary obstruction - searing. | 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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED (State nature of injury in PART I or PART II of item 18.) |
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|---------------------------------------|------------------|
| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year |
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| 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 COUNTY STATE |
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21. I attended the deceased from **8/8/59** to **3/16/60** and last saw her/him alive on **3/16/60**.
Death occurred at **7 A.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>M. O. Harral</i> (Degree or title) | 22b. ADDRESS 7205 W. Florissant | 22c. DATE SIGNED 3/17/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 3/18/60 | 23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Mo. |
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| 24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd. | 25. DATE RECD. BY LOCAL REG. MAR 17 1960 | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> |
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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 Albert R. Thompson

Licensed Embalmer No. 4237

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.