

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

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 915 N. GRAND, ST LOUIS, MO		Length of stay in 1b 331 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 VETS. ADMIN. HOSPT.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1734 <i>Washington Blvd</i> MILNER HOTEL Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EMIL	Middle B.	Last VOGT	4. DATE OF DEATH Month DECEMBER	Day 8	Year 1960
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5. SEX MALE	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 3/23/89	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) E. ST. LOUIS, ILL.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME THEODORE VOGT	13b. MOTHER'S MAIDEN NAME ELIZABETH DEHAAN	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 way or dates of service) YES	16. SOCIAL SECURITY NO. UNK.	17. INFORMANT RITA KEELEY, EDWARDSVILLE, ILL. (SISTER)	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) MALNUTRITION	DUE TO (b) MULTIPLE INFECTION <input checked="" type="checkbox"/> CELLULITIS, URINARY TRACT	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) ARTEROSCLEROTIC HEART DISEASE WITH CHRONIC BRAIN SYNDROME AND PSYCHOSES	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 Month, Day, Year	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. attended the deceased from 1/12/60 to 12/8/60 and last saw him live on 12/8/60	Death occurred at 9:05 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE ROBERT H. OLIN (Degree or title) M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 12/8/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 10-1960	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City, town, or county) (State) Canton Township Ill.
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24. FUNERAL DIRECTOR G. W. Breckler ADDRESS East St Louis Ill	25. DATE RECD. BY LOCAL REG. DEC 9 1960	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
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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 Frank Prokoff Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Not Embalmed  
Wm Morrison

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.