

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-039328**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9666**

STATE FILE NUMBER

**FILED OCT 26 1961**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</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>Bethesda Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4920 Chippewa St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>ELIZABETH</b> Last <b>VOGEL</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>17</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-1-1873</b>		9. AGE (last birthday) <b>87</b>	
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>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Evansville, Ind.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>August Schmidt</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Ulman</b>			14. NAME OF HUSBAND OR WIFE <b>Late William Vogel</b>			
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>Irene Vogel</b>		Address <b>4920 Chippewa St.</b>		
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>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Suddenly</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Fracture Left Hip</b>						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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Fell @ Home 4920 Chippewa</b>					
20c. TIME OF INJURY <b>7:00 p.m.</b>		Month, Day, Year <b>10-12-61</b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>At Home</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis,</b>		COUNTY <b>Mo.</b>		STATE	
21. I attended the deceased from <b>1946</b> , to <b>1961</b> and last saw him alive on <b>10/17/61</b> Death occurred at <b>12:20 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Preston C. Hall M.D.</b>				22b. ADDRESS <b>3902 N Lafayette</b>		22c. DATE SIGNED <b>10/18/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Oct. 20, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		(State)		
24. FUNERAL DIRECTOR <b>Kriegshausler 4228 S. Kingshighway Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 19 1961</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Ernest W. Spillars

Licensed Embalmer No. 4080

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

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.