

Registration District No.

1003

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5330 Pershing Ave.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Otto B. Vogel 240

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Dena Vogel 6. (c) Age of husband or wife if alive 68 years7. Birth date of deceased May 15 1967
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
72 2 4 hr. min.9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Retired11. Industry or business musician12. Name Benjamin Vogel13. Birthplace Germany
(City, town, or county) (State or foreign country)14. Maiden name Bertha Joseph15. Birthplace Germany
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Bertha Vogel(b) Address 5330 Pershing17. (a) Burial (b) Date thereof 7-21-39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Int. Sinai Cem.18. (a) Signature of funeral director H. Rindaloff(b) Address 3218 Delmar19. (a) July 20 1939 (b) J.D. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
 (c) City or town St. Louis 12
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5330 Pershing Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month July day 19
year 1939 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from July 19 39
12 1939 to July 19 39 1939
that I last saw him alive on July 19 39
and that death occurred on the date and hour stated above.Immediate cause of death Brown choleliths acute Duration 7 daysDue to cold bathDue to acute choleliths 7 days
caused by chr. endocarditisOther conditions Heart Hypertrophy chronic
(Include pregnancy within 3 months of death)Major findings: no 920
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Gas H. Mays (M. D. or other) _____Address University Club Bldg Date signed 7/20/39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.