

FILED JUN 20 1947

Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **5937**

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: Missouri Athletic Club  
(If not in hospital or institution, write street number or location)  
405 Washington  
 (d) Length of stay: In hospital or institution 1  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME John William Vogler  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.  
 6. (b) Name of husband or wife Margaret Vogler 6. (c) Age of husband or wife if alive 50 years  
 7. Birth date of deceased Feb. 10th., 1895  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
52 4 7 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Railway Supplies

11. Industry or business \_\_\_\_\_

12. Name Fred W. Vogler

13. Birthplace Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Grace Mohr

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Vogler  
 (b) Address 4247 Magnolia

17. (a) Burial St. Peters (b) Date thereof 6-20-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Arthur J. Donnelly  
 (b) Address 3840 Lindell Blvd.

19. (a) June 20 1947 (b) \_\_\_\_\_  
(Date received for total registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 405 Washington  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country U.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 1947  
 year 1947 hour 7 minute 45 .M.

21. I hereby certify that I attended the deceased from May 20, 1947 to June 17, 1947;  
 that I last saw him alive on June 17, 1947;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure  
acute (fibrillation?)  
Atherosclerotic Heart Disease  
 Due to alcoholism chronic  
cirrhosis of liver (jaundice)  
 Due to Epilepsy (Grand Mal)

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 1/24  
 Of operations \_\_\_\_\_

Of autopsy See above

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 \_\_\_\_\_  
 Signature F. R. Bradley (M. D. or other) \_\_\_\_\_  
 Address St. James Hospital Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Rundell

**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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 5937

Registration District No. 318

Primary Registration District No. 1003

**1. PLACE OF DEATH:**

(a) County.....  
 (b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(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** John W. Vogler  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced.....  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
 7. Birth date of deceased Feb 10 1949  
(Month) (Day) (Year)

**8. AGE:** Years 52 Months Days (Unless than one day)  
 hr. min.

9. Birthplace.....  
(City, town, or county) (State or foreign country)

10. Usual occupation..... Salvage Supplies

11. Industry or business.....

**MOTHER FATHER**

12. Name.....  
 13. Birthplace.....  
(City, town, or county) (State or foreign country)  
 14. Maiden name.....  
 15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant.....  
 (b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....  
(Month) (Day) (Year)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
 (b) Address.....

19. (a) (Date received local registrar)..... (b) J. F. Bredeck  
(Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits, write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month..... year 1949 hour..... minute..... M.  
 21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him/her alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Due to.....  
 Due to.....  
 Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....  
 Of autopsy.....

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..... (M. D. or other).....  
 Address..... Date signed.....

**SUPPLEMENTARY**

Duration.....  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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