

FILED MAR 22 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9269

State File No. ....

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 72

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>BONNE TERRE</u>	c. LENGTH OF STAY (in this place) <u>6 Mo</u>	c. CITY OR TOWN <u>BONNE TERRE</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BONNE TERRE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>317 FITE ST</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>NANCY</u>	b. (Middle) <u>M</u>	c. (Last) <u>VOGT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 10 1955</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 5, 1891</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and State or Foreign Country) <u>DOE RUN Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>ANCE BAYLESS</u>	13b. MOTHER'S MAIDEN NAME <u>REBECCA ELLIGE</u>	14. NAME OF HUSBAND OR WIFE <u>EDWIN B. VOGT</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>EDWIN B. VOGT</u>	ADDRESS <u>BONNE TERRE Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Cervix</u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 mos</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>to metastasis to</u>		
	DUE TO (c) <u>ovum</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>171X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug, 1953, to March 10, 1955, that I last saw the deceased alive on March 10, 1955, and that death occurred at 11:30 m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. L. Foster MD</u> (Degree or title)	23b. ADDRESS <u>Desloge Mo</u>	23c. DATE SIGNED <u>3-12-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>MARCH 13, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ST. FRANCOIS MEMORIAL</u>	24d. LOCATION (City, town, or county) (State) <u>BONNE TERRE Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Mar. 12, 1955</u>	REGISTRAR'S SIGNATURE <u>Eather Rudloff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Bertram</u>	ADDRESS <u>BONNE TERRE Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

*C. J. Claywell*

Licensed Embalmer No. *370*

P. O. Address *Barnes*

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.