

FILED JAN 11 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42652

State File No. 10988

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____		
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>St. Louis</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>5 MO.</b>		c. CITY OR TOWN <b>Webster Groves</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>956 Hamilton Ave.</b>				e. STREET ADDRESS (If rural, give location) <b>721 N Forest Ave.</b>				
3. NAME OF DECEASED (Type or Print) <b>CHARLOTTE VOGELE STARKER</b>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <b>12-15-1955</b>		(Month) (Day) (Year)		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>4-6-1895</b>		9. AGE (In years last birthday) <b>60</b>		10. IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>August Vogele</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Richter</b>		14. NAME OF HUSBAND OR WIFE <b>Rudolph Starker</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>496-28-5560</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. R.A. Ecoff 718 N Forest</b>				
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) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES <b>Arteriosclerosis a.m.</b> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>331x</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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)				
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?				
22. I hereby certify that I attended the deceased from <b>Nov 18, 1955</b> , to <b>Dec 12, 1955</b> , that I last saw the deceased alive on <b>Dec 12, 1955</b> and that death occurred at <b>5:30 a.m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>Carl C. Frick</b> (Degree or title)				23b. ADDRESS <b>327 E. Parkwood</b>		23c. DATE SIGNED <b>12-15-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12-17-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Kirkwood Mo.</b>		
DATE REC'D BY LOCAL REG. <b>DEC 15 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D. Starker - Admch Webster Groves Mo</b>		F. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS _____		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Dr. Carl C. Frick 227 E. Lockwood

S. B. (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No. ....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Leslie Welch*.....

Licensed Embalmer No. *43*

P. O. Address *Hopster St*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.