

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29260

FILED SEP 6 1956

STATE FILE NUMBER  
7656

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

Health,  
Welfare  
Public  
Services

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>		Length of stay in 1b _____	d. STREET ADDRESS <b>17 2609 South Grand Ave.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD</b> <small>First</small> <b>B. BRET</b> <small>Middle</small> <b>VOGLER</b> <small>Last</small>			4. DATE OF DEATH <b>AUGUST 16, 1956</b> <small>Month Day Year</small>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 13, 1879</b>	9. AGE (In years last birthday) <b>77</b> IF UNDER 1 YEAR: Months <b>5</b> Days <b>3</b> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ernest Vogler</b>			14. MOTHER'S MAIDEN NAME <b>Helen Zeitler</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>488-01-9933A</b>	17. INFORMANT <b>Mrs. Wainwright 2609 South Grand Avenue</b> Address _____			
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>chronic myocarditis</b>					INTERVAL BETWEEN ONSET AND DEATH _____	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gov'l Asc, Chr. Brain Syndrome, dehydration, malnutrition.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>422.1</b>			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <b>8/1/56</b> to <b>8/16/56</b> and last saw her alive on <b>8/16/56</b> Death occurred at <b>10:50 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Ronald H. Severs, M.D.</b>			22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>8/17/56.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8 / 20 / 56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Churchyard</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>C. R. Lupton &amp; Sons 7233 Delmar Bly'd.</b>			25. DATE RECD. BY LOCAL REG. <b>AUG 17 1956</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</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 embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Arnold W. Schoene*

Licensed Embalmer No. *386*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitute's 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.