

Health,
Welfare
Public
Service

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20439

STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5297 Registrar's No. 884

1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Liberty</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>IOOF Hospital</u>		Length of stay in lb <u>1 month</u>	d. STREET ADDRESS <u>207 N. Prairie</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>William</u> Last <u>Vogt</u>			4. DATE OF DEATH <u>June 29, 1957</u> Month <u>June</u> Day <u>29</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1881</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	11. BIRTHPLACE (City and state or country) <u>Grand Pass, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>W. J. Vogt</u>			14. MOTHER'S MAIDEN NAME <u>Martha Hoff</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>191-12-7835</u>	17. INFORMANT <u>Roda Brown El Monte California</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
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.) _____				
20c. TIME OF INJURY Hour _____ 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 <u>Liberty</u>		COUNTY <u>Missouri</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>for 570 June</u> and last saw <u>him</u> alive on <u>6/29/57</u> Death occurred at <u>8:40 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Joseph Gredson M.D.</u>			22b. ADDRESS <u>Liberty, Mo</u>		22c. DATE SIGNED <u>7/1/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7-2-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Liberty, Missouri</u>		
24. FUNERAL DIRECTOR <u>Tyler-Pasley Liberty, Missouri</u>		ADDRESS <u>Liberty, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>7-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u>	

(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 *John Basley*.....

Licensed Embalmer No. *430*

P. O. Address *Liberty*

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