

Health,  
Welfare  
Public  
Service

FILED MAY 12 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016761

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1211

300  
-57  
4003

|   |  |  |  |   |  |  |   |   |   |   |       |                                |  |
|---|--|--|--|---|--|--|---|---|---|---|-------|--------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>                |  |  |   |   |   |   |       |                                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kirkwood</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | c. CITY OR TOWN <u>Webster Groves</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |   |   |       |                                |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>   |  |  | Length of stay in lb<br><u>5 days</u>  |   | d. STREET ADDRESS<br><u>478 Florence Ave</u> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |   |   |       |                                |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Harry Bernhardt Voellner</u>   |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>May 3, 1958</u>  |  |  |   |   |   |   |       |                                |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>July 16, 1884</u>   |   | 9. AGE (In years last birthday)<br><u>73</u>                    |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |       | IF UNDER 24 HRS.<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman retired</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Specialty</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>Cleveland, Ohio</u>                 |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |   |       |                                |  |
| 13a. FATHER'S NAME<br><u>Hermann Voellner</u>   |  |  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Louise Sahnell</u>  |  |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Voellner Louada McCaughen</u> |   |   |       |                                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |  |  | 16. SOCIAL SECURITY NO.<br><u>488-05-3898</u>   |  | 17. INFORMANT<br>Address<br><u>Mrs. H. B. Voellner 478 Florence Ave</u>              |   |   |   |   |       |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Trigeminal Neuralgia</u>  |  |  |  |   |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yr</u>   |       |                                |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Heart Disease</u>   |  |  |  |   |  |  |   |   |   | <u>2 yr</u>   |       |                                |  |
| DUE TO (c) <u>4201</u>  |  |  |  |   |  |  |   |   |   |   |       |                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |  |  |   |  |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |                                |  |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour Month, Day, Year<br>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 <u>April 8, 1958</u> to <u>May 5, 1958</u> and last saw <sup>her</sup> him alive on <u>May 5, 1958</u><br>Death occurred at <u>9:00 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |  |   |  |  |   |   |   |   |       |                                |  |
| 22a. SIGNATURE (Degree or title)<br><u>Robert Woodsey M.D.</u>  |  |  |  |   |  | 22b. ADDRESS<br><u>6944 Chippewa Ave.</u>  |   |   |   | 22c. DATE SIGNED<br><u>May 5, '58</u>   |       |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |  | 23b. DATE<br><u>5-3-1958</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Bellefontaine Cem.</u>   |  |  | 23d. LOCATION (City, town, or county)<br><u>St. Louis, Mo.</u>                        |   |   | (State)   |       |                                |  |
| 24. FUNERAL DIRECTOR<br><u>Mittelberg Funeral Home, Inc.</u><br><u>Webster Groves, Mo.</u>  |  |  |  | 25. DATE RECD. BY LOCAL REG.<br><u>5-5-58</u>   |  | 26. REGISTRAR'S SIGNATURE<br><u>Herbert R. Donke M.D.</u>                            |   |   |   |   |       |                                |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Elmo R. Sedwell*

Licensed Embalmer No. *4077*  
P. O. Address *St. Louis*

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.