

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042902

STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2906

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NORMANDY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Normandy 4170</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5323 Lucas &amp; Hunt</b>		Length of stay in lb <b>YRS</b>	d. STREET ADDRESS (If outside, give location) <b>5323 Lucas &amp; Hunt</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle Last <b>VOELLMECKE</b>			4. DATE OF DEATH Month <b>11</b> Day <b>9</b> Year <b>58</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-1908</b>	9. AGE (In years last birthday) <b>50</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>director of service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Riverview High Sch.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>George Voellmecke</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Evans</b>		14. NAME OF HUSBAND OR WIFE <b>Florence Voellmecke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>488-09-5258</b>		17. INFORMANT Address <b>5323 Lucas</b> <b>Florence Voellmecke, and Hunt Rd.</b>	
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>unknown natural causes</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>795A</b>
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? 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.)		
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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Herbert R. Domke</b>			22b. ADDRESS <b>801 S. Brentwood, Clayton, Mo.</b>		22c. DATE SIGNED <b>11/20/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>11-10-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOCAL</b>		23d. LOCATION (City, town, or county) (State) <b>Sandoval, Illinois</b>
24. FUNERAL DIRECTOR ADDRESS <b>Cox-Martin, Sandoval, Illinois</b>			25. DATE RECD. BY LOCAL REG. <b>11-10-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Domke M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. 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

MEDICAL CERTIFICATION

*m*

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 *Plarence M. Billo* .....

Licensed Embalmer No. *4375* .....

P. O. Address *St. Charles, Mo* .....

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.