

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046448
STATE FILE NUMBER

FILED DEC 22 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's

11711

5. 300
1-57

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.

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 Missouri b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Length of stay in 1b 30 years | d. STREET ADDRESS (If outside, give location) 4131a South Grand | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last ALVIN WILLIAM VOGT | | | 4. DATE OF DEATH Month Day Year DECEMBER 2, 1958 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 17, 1906 | 9. AGE (In years last birthday) 52 | 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) Bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | 11. BIRTHPLACE (City and state or country) New Minden, Illinois | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME August Vogt | | 13b. MOTHER'S MAIDEN NAME Alice Woker | | 14. NAME OF HUSBAND OR WIFE Mrs. Margaret Erbe Vogt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 493-03-1529 | 17. INFORMANT Address Mrs. Margaret Vogt, 4131a So. Grand | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 HOURS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) METASTATIC CARCINOMA, PRIMARY SITE SIGMOID COLON | | | | | 4 MONTHS |
| DUE TO (c) 153.3 | | | | | |
| 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 <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 NOV. 23, 1958 to DEC. 2, 1958 and last saw her ^{her} _{him} alive on DEC. 2, 1958 Death occurred at 8:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>C. D. McMillan, M.D.</i> (Degree or title) M. D. | | | 22b. ADDRESS BARNES HOSPITAL | | 22c. DATE SIGNED 12/3/58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Dec. 5, 1958 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri. |
| 24. FUNERAL DIRECTOR Beiderwieden F.H.Inc. 1936 St. Louis | | | 25. DATE RECD. BY LOCAL REG. DEC 5 '58 | 26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i> | |

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 *Homer W. Britz*

Licensed Embalmer No. *3882*
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.