

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016140  
STATE FILE NUMBER

FILED MAY 7 1959

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 1007

300  
1-57

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1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maplewood</b>		Inside Limits Yes <input checked="" 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 (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Maplewood Nursing</b>		Length of stay in lb <b>2 1/2 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>6020 Marquette</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Home</b> Middle <b>H.</b> Last <b>VOGEL</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>11</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1871</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Twist Maker (Retired)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Liggett &amp; Myers Tob. Co.</b>	11. BIRTHPLACE (City and state or country) <b>Henderson, Ky.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Karl Henry Vogel</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Late Clara L. Vogel</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>492-07-2540</b>	17. INFORMANT Address <b>Mabel Bishop 6020 Marquette Ave.</b>
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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>CEREBRAL ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	334x
	DUE TO (c) _____	
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.) <b>ITEM 16 CORRECTED</b>
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	BY AFFIDAVIT OF <b>Funeral Director</b> <b>6-29-59</b>

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
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21. I attended the deceased from **1956** to **1959** and last saw him alive on **APRIL 10, 1959**  
Death occurred at **9:30 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>William C. Feltz M.D.</b>	22b. ADDRESS <b>3720 WASHINGTON</b>	22c. DATE SIGNED <b>4/13/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>Apr. 14, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>4-13-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 JAMES J. KRIEGSHAUSER, Student Embalmer No. 576 working under my personal supervision.

Student James J. Kriegshauser  
Signature of Student Embalmer

Signed Edwin A. McArthur

Licensed Embalmer No. 3024

P. O. Address .....

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.