

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013717  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1079

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

14000  
24000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |   |  |
|---|---|---|--|
| 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>MO.</u> b. COUNTY <u>ST. LOUIS</u>                     |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>GLASGOW VILLAGE</u>   |   | Length of stay in 1b<br><u>1 YR.</u>  | c. CITY OR TOWN <u>GLASGOW VILLAGE</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>324 CAMERON RD.</u>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>324 CAMERON RD.</u><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>KATHERINE</u> Middle <u>VOGT.</u> Last <u>VOGT.</u>   |   |   | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>2</u> Year <u>1962</u>   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-26-1880</u>  |
| 9. AGE (last birthday) <u>81</u>  |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HR<br>Hours _____ Min. _____   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>HOME</u>  | 11. BIRTHPLACE (City and state or country)<br><u>ST. LOUIS, MO.</u>  |
| 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |   | 13a. FATHER'S NAME<br><u>JOHN MUELLER</u>   |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>UNK.</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>AUGUST C. VOGT</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>NONE</u>  | 17. INFORMANT<br><u>AUGUST E. VOGT 324 CAMERON RD. GLASGOW VILLAGE, MO.</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>Cerebral Vascular Thrombosis</u>   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>  |
| DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>   |   |   | <u>5 years</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)   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m. Month, Day, Year _____  |   |   |  |
| 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>1950</u> to <u>April 2, 1962</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>April 2, 1962</u><br>Death occurred at <u>7 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Charles H. Older, M.D.</u>   |   | 22b. ADDRESS<br><u>3191 N. Grand</u>  | 22c. DATE SIGNED<br><u>April 3-62</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE<br><u>4-5-1962</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>NEW BETHLEHEM CEM.</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>ST. LOUIS COUNTY, MO.</u>  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>SUEDEMEYERSONS 3934 N. 20TH ST. ST. LOUIS, MO.</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>4-4-62</u>   | 26. REGISTRAR'S SIGNATURE<br><u>John B. Murphy M.D.</u>  |

USE BLACK INK OR OR TYPEWRITER RIBBON

**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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis 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.