

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12837
 Do not use this space.

REC'D MAY 10 1938

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1008**
 (c) City **St. Louis, Mo.** (d) Street No. **5029 Milentz** St. **Okawville, Ill.**
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. / mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Sophie Vogele **240**
 (a) Residence, No. **5029 Milentz, Ave.** St. **NR Okawville, Ill.**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John M. Vogele**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 26/1877.**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 9 16
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) **1933.** 11. Total time (years) spent in this occupation **35 yrs.**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4-12-1938**
 22. I HEREBY CERTIFY, That I attended deceased from **3-23-1938** to **4-12-1938**
 I last saw h.e.r. alive on **4-12-1938** Death is said to have occurred on the date stated above, at **7:30** A.m.
 The principal cause of death and related causes of importance were as follows:

CARCINOMATOSIS - ABDOMINAL ± **11-37** Date of onset
METASTASES TO LIVER
(PRIMARY SITE UNDETERMINED)
MYOCARDITIS, CHR.

Other contributory causes of importance: **53K**

Name of operation **NONE** Date of
 What test confirmed diagnosis? **X-RAY** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify _____
 (Signed) **A. J. ...** M. D.
 (Address) **2790 S. Cherokee St.**

12. BIRTHPLACE (CITY OR TOWN) **Okawville** / **1**
 (STATE OR COUNTRY) **Illinois**

FATHER 13. NAME **Christian Fehlber** / **6**
 14. BIRTHPLACE (CITY OR TOWN) **Unk.** / **1**
 (STATE OR COUNTRY) **Germany**

MOTHER 15. MAIDEN NAME **Mary Maehring**
 16. BIRTHPLACE (CITY OR TOWN) **Okawville**
 (STATE OR COUNTRY) **Illinois**

17. INFORMANT **Mrs. C. H. Fischer**
 (ADDRESS) **% 5029 Milentz, Ave**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **Okawville, Ill.** DATE **4/16/1938**

19. FUNERAL DIRECTOR (NAME) **Albert H. Hoppe, Inc.**
 (ADDRESS) **429 N. Euclid, Ave.**

20. FILED **APR 12 1938**
J. D. ...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Registered Apprentice No., working under my personal supervision.

Signed

Albert G. Hooper

Licensed Embalmer No.

2971

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 this body is not embalmed, above space should be left blank.