

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.

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

38794
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Two Primary Registration District No. 1002 Registered No. 4538
(c) City Kansas City, Mo. (d) Street No. St. Vincent's Hospital St. _____
(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

Infant Vogel Vogel
(a) Residence, No. 2502 Brighton St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Infant</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 28, 1939</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, <u>3 1/2</u> hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	<u>None</u>
	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)	11. Total time (years) spent in this occupation
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Kansas City, Missouri</u>
	13. NAME	<u>John J. Vogel</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Kansas City, Kansas</u>
	15. MAIDEN NAME	<u>Huldged Vietz</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>St. Louis, Missouri</u>
	17. INFORMANT (ADDRESS)	<u>John J Vogel</u> <u>2502 Brighton</u>
	18. BURIAL, CREMATION, OR REMOVAL	
	PLACE	<u>St. Marys</u> DATE <u>Nov 29, 1939</u>
	19. FUNERAL DIRECTOR (NAME) (ADDRESS)	<u>Thomas E Quirk</u> <u>4316 Troost Ave</u>
	20. FILED	<u>Nov. 29</u> 19 <u>39</u> <u>M.M. Grome</u> Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 28, 1939, 19 39

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1939, to Nov 28, 1939
I last saw h. alive on _____, 19 39. Death is said to have occurred on the date stated above, at 8.05 a.m.
The principal cause of death and related causes of importance were as follows:
Prematurity Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? Physical Was there an autopsy? _____

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? _____
If so, specify _____ (Signed) Eugene S. Langhans, M. D.
(Address) 1102 Troost Ave City

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.....

Licensed Embalmer No.....

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.