

No. 2
M-5-43
5-17-39
I X3671

FILED FEB 18 1946

Registration District No. 370 Primary Registration District No. 3058 Registrar's No. 27

1. PLACE OF DEATH:

(a) County ST. CHARLES

(b) City or town ST. CHARLES RURAL
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
EVANGELICAL EMMAUS HOME
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 YEARS 7 MONTHS
(Specify whether years, months or days) 1 DAY

In this community 1 DAY

3. (a) PRINT FULL NAME FREDERIKA VOGT

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUGUST 8 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>5</u>	<u>21</u>	hr. _____ min. _____

9. Birthplace GERMANY
(City, town, or county) (State or foreign country)

10. Usual occupation GENERAL HOUSEWORK

MOTHER FATHER

11. Industry or business _____

12. Name JACOB V. VOGT 4

13. Birthplace GERMANY
(City, town, or county) (State or foreign country)

14. Maiden name CHRISTINA SHOCK

15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant Theophil Stoerner

(b) Address ST. CHARLES, Mo.

17. (a) Burial (b) Date thereof Jan 31 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST CHARLES M.O.

18. (a) Signature of funeral director Washman Bone

(b) Address St Charles Mo

19. (a) Jan 31 46 (b) Frankie Himmelt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State NEBRASKA (b) County 49

(c) City or town BEAVER CROSSING 25
(If outside city or town limits, write "RURAL")

(d) Street No. _____ 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 29
year 1946 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 1st 1946 to Jan 29th 1946
that I last saw her alive on Jan 27th 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Broken compensation 5 day

Due to Chronic Myocarditis

Due to Gen Arterio-sclerosis

Other conditions _____
*(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 93d

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature A.P. Eriol Schmitz, M.D.
Address St Charles Mo. Date signed 1/29/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 2-15-46

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. 3155
P. O. Address St Charles 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 this body is not embalmed, fact should be so stated above.