No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11645

Registration District No. #4053 318 Primary Registration District No. 1003 Registrar's No. 3072

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 65 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 060 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2711 Union (near) 17
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Joseph Vogel

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife MAMIE (NEE) HICKS

6. (c) Age of ~~husband or~~ wife if alive 65 years

7. Birth date of deceased 10 (Month) 1 (Day) 1879 (Year)

8. AGE: 67 Years | 11 Months | 6 Days | If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation CITY EMPLOYEE

11. Industry or business

FATHER
12. Name Louis Vogel
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant MRS MAMIE VOGEL
(b) Address 2711 UNION AVE

17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 3-21-1947 (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA

18. (a) Signature of funeral director JOHN A BARRETT
(b) Address 7814 UNION AV

19. (a) MAR 22 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20th year 1947 hour 7:25 minute A M.

21. I hereby certify that I attended the deceased from , 19 , to 3/20/47 , 19 ; that I last saw him alive on 3/20/47 , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart disease

Due to asthma

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy as above

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Peter Thomas M.D.

Address 1515 Lafayette Date signed 3/20/47

(Licensed Embalmer's Statement on Reverse Side)

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. 1861

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, fact should be so stated above.