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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19459

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5256

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME George L. Vogel
3. (b) If veteran, name war. 3. (c) Social Security No.
4. Sex Male 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 February 26, 1901
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	46	2	29	hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Brew Master

11. Industry or business
12. Name Charles Vogel
13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Rose Ambs
15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Ambs Vogel
(b) Address 4132 Louisiana Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-47
(Month) (Day) (Year)
(c) Place: burial or cremation Resurrection Cem.

18. (a) Signature of funeral director Southern Funeral Home
(b) Address 6322 S. Grand Blvd.
19. (a) J. F. Bredbeck (Date received local registrar) (b) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4132 Louisiana Ave,
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 25th
year 1947 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from Feb 47
19 to death 19 47
that I last saw him alive on 5-25-47
and that death occurred on the date and hour stated above.

Immediate cause of death
Congestive heart failure
Due to Rheumatic heart disease
Other conditions Cholelithiasis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy as above
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
Signature Fabian J. Burke (M. D. or other) M.D.
Address 5203 Chippewa Date signed 5-26-47

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

DR. FABIAN J. BURKE

5203 CHIPPewa

FL 6017

1784

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.....

J. Wm Bentley

Licensed Embalmer No. 3653

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 this body is not embalmed, fact should be so stated above..