

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

Do not use this space.

10412

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **Shrews** No. **City Hospital**

File No.

Registered No. **3003**

St. Ward)

2. FULL NAME

(a) Residence. No. **4222 222** St. **9** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **40** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* | **4. COLOR OR RACE** *White* | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *(write the word)* **MARRIED**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Grace Vogt.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 4 - 1886*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 8 11

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Chauffeur.*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Henry Vogt.*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

12. MAIDEN NAME OF MOTHER *Anna Knuse*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

14. INFORMANT (Address) *Shrews City Hospital*

15. FILED **MAR 29 1927** *Max B. Starkeoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 26 1927*

17. I HEREBY CERTIFY That I attended deceased from *March 20, 1927* to *March 26, 1927* that I last saw him alive on *March 26, 1927*, and that death occurred on the date stated above, at *1538* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
*Chronic Arteriosclerosis
Cerebral Disease*

CONTRIBUTORY (SECONDARY) *900W*

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *[Signature]* M. D.
3/27, 1927 (Address) *City Hospital*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Freidens* **DATE OF BURIAL** *Mar 29 1927*

20. UNDERTAKER *W. G. Leidner and Co. 1417 N. Market St.*

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.

WHILE PRINTING, WITH UPDATING INK—THIS IS A PERMANENT RECORD

Voght: