MAY 25 1927

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

Do not use this space.

11044

1. PLACE OF DEATH
County: Buchanan
Township:
City: St. Joseph, (No. 811, No. 23rd. St. St. Ward)
Registration District No. 85
Primary Registration District No. 1001
File No.
Registered No. 429

2. FULL NAME: Louise Vogel
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Charles Vogel

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan, 1, 1840

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
87	3	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home.
(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): Mahren, W. Prussia, Germany

PARENTS
10. NAME OF FATHER: Jacob Groenke
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany.
12. MAIDEN NAME OF MOTHER: ------ Lemke
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany.

14. INFORMANT (Address): Miss Erna Vogel, 811 No. 23rd. St.

15. FILED APR 23 1927 19 John G. Utz, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr, 23, 19 27

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1927, to April 23, 1927, that I last saw her alive on April 23, 1927, and that death occurred, on the date stated above, at 5.30 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
90B
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (SECONDARY): None
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Gustav A Lam, M. D
4/23/1927 (Address) Kirk Bldg

*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: Ashland Cemetery
DATE OF BURIAL: Apr, 25, 19 27

20. UNDERTAKER: Walter Meierhoffer
ADDRESS: 1302 Faraon 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.

JAN 2 0 1958

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1. PLACE OF DEATH

County Buchanan — Registration District No. 85 — File No.

Township — Primary Registration District No. 1001 — Registered No. 429

City St. Joseph (No. ..... St. ..... Ward)

2. FULL NAME Louise Vogel

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: P.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wd.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER Buchanan X Lemke

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

14. INFORMANT
(Address)

15. FILED 4/23 1927 John G. Wtz
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 23 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(SECONDARY)

.....(duration) ..... yrs. ..... mos. ..... ds.

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) ....., M. D

, 19 (Address)

*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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTAL

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.

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