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

Do not use this space.

35260

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. 3524 N. Taylor Ave St. ..... Ward)

File No. .....

Registered No. 10439

2. FULL NAME Julia M Vogel

(a) Residence. No. 3524 N Taylor Ave St. 10 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: Female

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 John B. Vogel

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 5 1863

7. AGE: Years 64 | Months 6 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Jacob Lorenzen

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

12. MAIDEN NAME OF MOTHER Frederika Brasse

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

14. INFORMANT John B. Vogel
(Address) 3524 N. Taylor Ave

15. FILED NOV 22 1927 Max C Starkcoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 19 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1927, to Oct. 19, 1927 that I last saw her alive on Nov 17, 1927, and that death occurred, on the date stated above, at 12 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis (Paranchymatous)

131

936 (duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic

(duration) yrs. 2 mos. 14 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? .....

(Signed) Theodore Greene, M. D

, 19 (Address) 5435 Easton

*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: St Peters Cem

DATE OF BURIAL: Nov. 22 1927

20. UNDERTAKER: Drehmann Harral

ADDRESS: 1905 Union Blvd

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.

5435 S. Easton Ave
8-9 AM
2-3
7-8 PM
Forest 3987