

JUL 25 1928

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

Do not use this space

*Dr. Shetler 20419*  
*St. John Hosp*  
File No. \_\_\_\_\_  
Registered No. *478* (Ward)

1. PLACE OF DEATH  
County *St Louis* Registration District No. *318*  
Township \_\_\_\_\_ Primary Registration District No. *St John Hosp*  
City *Springfield* (N. \_\_\_\_\_) \_\_\_\_\_ (Ward)  
2. FULL NAME *Miss Dela Vogel*  
(a) Residence No. *450 E Madison* 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) *Single*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 4, 1874*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
*54*      *1*      *25*

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) *Mo*

10. NAME OF FATHER *Henry P Vogel*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) *Mass*  
12. MAIDEN NAME OF MOTHER *Dora Cleburg*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) *Germany*

14. INFORMANT *Mrs Geo Messel*  
(Address) *734 So Jefferson*

15. *6-29-28* *October 28*  
FILED \_\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-29-28* 19*28*  
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 \_\_\_\_\_ *2 a* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*8:30*  
*Cerebral Hemorrhage*  
*Apoplexy* (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *1* ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED? *no*  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clonus*  
(Signed) *W. A. Beebe*, M. D.  
*Springfield* (Address)

\*State the DISEASE CAUSING DEATH or in death 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 \_\_\_\_\_  
*Maple Park Cemetery* *6/30* 19*28*

20. UNDERTAKER *H. H. G. G. G.* ADDRESS *Springfield*

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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