

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.

MAY 26 1932

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

13473

1. PLACE OF DEATH

County Perry
Towship Union
City Union (No.)

Registration District No. 969
Primary Registration District No. 5879

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)
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 M- 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9, 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
80 9 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 125 at Home 77
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 10-12
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Goshua Mo
(STATE OR COUNTRY) 1

10. NAME OF FATHER August Vogel

11. BIRTHPLACE OF FATHER (CITY OR TOWN) 10
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Katharine Deering

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

14. INFORMANT John Vogel
(Address) Uniontown Mo

15. FILED 4-29-32 C. A. Amacher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 25 1932

17. I HEREBY CERTIFY, That I attended deceased from March 19, 1932 to April 25, 1932, that I last saw him alive on April 20, 1932, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Hepatic calculi or Gall Stones, with obstruction of common duct, resulting in infection, inflammation and adhesions (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Infirmities of age (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1-20-32
IF NOT AT PLACE OF DEATH? 1

() DID AN OPERATION PRECEDE DEATH? No. DATE OF 1

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) C. B. Brown, M. D.

, 19 (Address) Old Appleton Mo.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Uniontown Mo 4-28 1932

20. UNDERTAKER

ADDRESS

Joellus Young, Perryville Mo.

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

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1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....)..... St..... Ward.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. 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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from.....
 that I last saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. mos. da.

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. (See reverse side for additional space.)

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