

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.

RECORDED MAR 13 1939

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

4943  
Do not use this space.

1. PLACE OF DEATH

(a) County.....  
 (b) Township.....  
 (c) City ST. LOUIS (d) Street No. 3650 ALBERTA St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 42 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

791  
1003

Registered No. 1636

2. PRINT FULL NAME 240 BETTIE K. VOGEL

(a) Residence, No. 3650 ALBERTA St. 15  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUG. 4, 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
59 6 14

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) Jan. 22, 1939 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maxwell, Mo.

FATHER 13. NAME John Zipp,

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Katherine Simon,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maxwell, Mo.

17. INFORMANT (ADDRESS) Frank J. Vogel  
3650 Alberta

18. BURIAL, CREMATION, OR REMOVAL PLACE Paul Gen. Nev. SS Pater & DATE 2/21/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) OSCAR J. HOFFMEISTER  
4016 Chippewa St.

20. FILED FEB 20 1939 J. B. Brubaker  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-24, 1939 to 2-18, 1939  
 I last saw her alive on 2-18, 1939. Death is said to have occurred on the date stated above, at 11:50 p.m.

The principal cause of death and related causes of importance were as follows:

Thrombosis mid cerebral artery  
left Hemiplegia (partial)  
 Date of onset days

Other contributory causes of importance:  
none

Name of operation none Date of.....  
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify (Signed) Walter M. Jones, M. D.  
 (Address) 3400 Meramec

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Edwin H. Leibinger*

Licensed Embalmer No. *4049*

P. O. Address *4016 Clippewa*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**