20 1939

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37188

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1837

1. PLACE OF DEATH: REC'D NOV 9 1939

(a) County St Louis

(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
8610 Lackland
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 25 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County St Louis

(c) City or town Overland
(If outside city or town limits, write "RURAL")

(d) Street No. 8610 Lackland
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Margeret B. Vogel 240

3. (b) If veteran, name war ////////////// 3. (c) Social Security No. ////////////

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John Vogel 6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 6 1860 (Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Louisville Kentucky (City, town, or county) (State or foreign country)

10. Usual occupation Registered Nurse 1

11. Industry or business

FATHER
12. Name Egan 5
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mackie 1
15. Birthplace Scotland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Shirley Vogel
(b) Address 8610 Lackland Overland Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home
(b) Address 9222 Lackland Overland Mo

19. (a) OCT 20 1939 (Date received local registrar) (b) G. R. Meyer M.D. Dep. Jc (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month oct day 19
year 1939 hour 8 15 minute P M.

21. I hereby certify that I attended the deceased from Aug 20, 1936 to Oct 19, 1939
that I last saw her alive on Oct 19, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Nephritis	3 yr
Chr. Myocarditis	1 yr
Due to age	
Due to Nephritis 5 D	
Other conditions Small Ca of Left Breast. (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Leo Reilly (M. D. or other)
Address 8105 Page Blvd Date signed 10/20/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 3-17-39 1 X19511

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 Al C Ortmann

Licensed Embalmer No. 3478

P. O. Address.....

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.