

No. 2
1-10-39
-17
X

MAY 15 1940

Registration District No. **791**

Primary Registration District No. **1003**

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

I. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4268 Maffitt Ave. **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 40 years
years, months or days)

8. (a) PRINT FULL NAME Lena Vogel **240**
3. (b) If veteran, name war ny 3. (c) Social Security No. no

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive none years
7. Birth date of deceased Oct 24 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 22 If less than one day hr. _____ min. _____

9. Birthplace Highland Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Peter Vogele

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Moll

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Neumann

(b) Address #268 Maffitt

17. (a) Calvary (b) Date interred April 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary cemetery

18. (a) Signature of funeral director J. J. [unclear]

(b) Address St. Louis

19. (a) APR 19 1940
(Date received local registrar) (City or town, State)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis **11**
(If outside city or town limit, write "RURAL")
(d) Street No. 4268 Maffitt
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
year 1940 hour 8 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 13
_____ 1939 to April 17 _____ 1940;
that I last saw him or alive on April 17 _____ 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage Duration 10 days

Due to Hypertension **1 yr.**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy _____

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? _____

While at work _____ (Specify type of place)
(e) Means of injury _____

23. Signature John [unclear] (M. D. or D.O.)

Address 720 Metropolitan Bldg. Date signed 4/18/40

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

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

Joseph A. Howard

Licensed Embalmer No. *4139*

P. O. Address *4212 S. T. Louis*

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

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