

DEC 18 1941 22

State File No. _____

Registration District No. _____

Primary Registration District No. 4373

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Madaway
(b) City or town Graham, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community 1 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madaway
(c) City or town Graham
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23
year 1941 hour about 1:30 minute PM M.
21. I hereby certify that I attended the deceased from Nov 23-41
19____ to _____ 19____;
that I last saw him alive on Nov 23- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____

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

Major findings:
Of operations _____
Of autopsy _____
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 R.M. Lilly (M.D. or other) MD
Address Marion, Mo Date signed 12-4-41

3. (a) PRINT FULL NAME Ronald Lee Vogel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced S. O
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 21 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months 5 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Graham Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Paul Vogel
13. Birthplace Parsons Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Clois Harvey
15. Birthplace Clinton Okla
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Vogel
(b) Address Graham, Mo

17. (a) Burial (b) Date thereof 11 24 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Graham, Mo

18. (a) Signature of funeral director Raymond Finner
(b) Address 957 South Main Marion, Mo
19. (a) Dec 2 (b) Raymond Finner
(Date received local registrar) (Registrar's signature)

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

074

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 William Campbell
Licensed Embalmer No.....

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, fact should be so stated above.

Registration District No. 622

Primary Registration District No. 4373

Registrar's No.

1. PLACE OF DEATH:

(a) County Napavay

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

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

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ronald L. Vogel

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11, day 12, year 1941, hour 10 minute 23 M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death neumonia

Due to lobar

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased June 2, 1946
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

MOTHER FATHER

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY 108

11/14/42

S-38970