

FILED APR 15 1946

Registration District No. _____ Primary Registration District No. **3009**

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Jackson
(c) Name of hospital or institution: North High St. /
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Entire life years, months or days

3. (a) PRINT FULL NAME Augusta L. Gockel
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 Widow
6. (b) Name of husband or wife Henry C Gockel 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 30 1870 (Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 23 If less than one day hr. _____ min. _____

9. Birthplace Near Jackson Mo. / (City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business _____

MOTHER FATHER
12. Name John G. Mogler
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Eva unknown
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant My Vanita Yorman
(b) Address Jackson, Mo.

17. (a) Buried (b) Date thereof 3-25-1946 (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (c) Signature of funeral director D. G. Seiber

(b) Address Jackson, Mo.
19. (a) 3-25-46 (b) D. G. Seiber (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Cape Girardeau
(c) City or town Jackson
(d) Street No. W High St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 23rd year 1946 hour 2:00 minute am

21. I hereby certify that I attended the deceased from Jan 12th 1946 to March 23 1946; that I last saw her alive on March 22 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to _____

Due to _____

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

Major findings: Of operations 92%
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 2

23. Signature C. M. Wiley (M. D. or other) Dr.
Address Cape Girardeau Mo. Date signed 3/23/46

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

RECEIVED

District Health Officer No. 4
District File Number 446-2007
Date Filed 4-13-46

AUG 26 1946

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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Luttsville, Mo.

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.