

FILED SEP 18 1946
Registration District No. 77

Primary Registration District No. 3016

State File No. _____
Registrar's No. 215

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Jefferson City
(c) Name of hospital or institution: St. Mary's Hospital
(d) Length of stay: 14 hospital or institution 6 weeks
In this community 46 years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cole 26
(c) City or town Jefferson City 5
(d) Street No. 1207 E. Miller 4
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

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

20. DATE OF DEATH: Month Sept day 9 year 1946 hour 8 minute 0 M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Oct 8 1862
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 31 1946 to Sept 9 1946 that I last saw her alive on Sept 9 1946 and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral thrombosis Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>11</u>	<u>1</u>	_____ hr. _____ min.

Due to Frederic Bauer
Due to _____

9. Birthplace Craig Bluff Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations: _____
Of autopsy _____

MOTHER FATHER

11. Industry or business At Home
12. Name Jacob Leopold 9
13. Birthplace Unknown 9
14. Maiden name Maiguit Hahn
15. Birthplace Unknown 9

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

16. (a) Informant Mrs. J. Hahn
(b) Address 1207 E. Miller J.C. Mo.
17. (a) Burial (b) Date thereof 9-11-46
(c) Place: burial or cremation St. Mary's Hospital
18. (a) Signature of funeral director Dorris Service
(b) Address 717 Jefferson
19. (a) 9-12-46 (b) R. P. Dorris MD
(Date received local registrar) (Registrar's signature)

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature Green C. Taylor (M. D. or other) M.D.
Address Jefferson City Date signed 9-11-46

RECEIVED
District Health Officer No. 9,
District File Number 9-46-142
Date Filed 9-17-46

REC'D

FACE V

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. H. Anderson
Licensed Embalmer No. 3641
P. O. Address Jemo.

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. 77 Primary Registration District No. 3016

1. PLACE OF DEATH:
(a) County cole
(b) City or town Jefferson City
(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 _____)
In this community _____ (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 Elizabeth Vogel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Oct 8 (Month) 8 (Day) _____ (Year)
8. AGE: Years 83 Months _____ 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)

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident (chance)
(b) Date of occurrence July 21, 46
(c) Where did injury occur? 116th Jefferson City, Mo
(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 Fall
23. Signature Leon A. Dayley (M. D. or other) M.D.
Address Jefferson City Date signed 10-15-46

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

SUPPLEMENTARY

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

28717

29881