DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32919

State File No.

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 349

1. PLACE OF DEATH:

(a) County Calloway

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

(c) Name of hospital or institution: State Hospital no 1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mo 25 days (Specify whether
In this community 2 mo 25 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 14

(c) City or town Webster Grove 1
(If outside city or town limits, write "RURAL")

(d) Street No. 7303 Nottingham 2
(If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lillian Voigt

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced Wid 1

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug. (Month) (Day) 1857 (Year)

8. AGE:

Years	Months	Days	If less than one day
89	2	14	hr. min.

9. Birthplace New York (City, town, or county) N.Y. 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name unknown 9
13. Birthplace (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name unknown 7
15. Birthplace (City, town, or county) 7 (State or foreign country)

16. (a) Informant Fred Voigt
(b) Address 7303 Nottingham Webster Grove Mo

17. (a) ~~Burial~~ Removal (Burial, cremation, or removal) (b) Date thereof Oct. 26 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Steelville Mo.

18. (a) Signature of funeral director Glen Y. Maupin
(b) Address 712 Court St. Fulton Mo

19. (a) 10-26-1946 (Date received local registrar) (b) Josie Morsiuskoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26
year 1946 hour 3 minute A M.

21. I hereby certify that I attended the deceased from Oct. 1, 1946, to Oct 26, 1946; that I last saw her alive on Oct 25, 1946, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	
Due to Generalized arterio sclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

93D

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 Forrest Thomas (M. D. or other)
Address Fulton Mo Date signed 10/26/46

58

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT

2

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 11/6/46

OFFICIAL RECORD

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 Glen J. Maupin

Licensed Embalmer No. 2722

P. O. Address Fulton, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 349

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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
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 Lillian Voigt

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, ~~married~~, divorced

6. (b) Name of husband or wife DK

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

7. Birth date of deceased Aug (Month) 18 (Day) 85 (Year)

8. AGE: Years 89 Months 2 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

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

19. (a) 10-26-1946 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26
year 1946 hour minute M.

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

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A

32919