

FILED AUG 29 1950 STANDARD CERTIFICATE OF DEATH

State File No. 28761
Registrar's No. 6873

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City 4336	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hos'p.		STREET ADDRESS 6820 Delmar Ave		(If rural, give location) /	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) RACHEL	b. (Middle) EBERT	c. (Last) VOGEL	(Month) August	(Day) 12,	(Year) 1950
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 8 1868	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Memphis Tenn.	

13a. FATHER'S NAME Samuel Ebert		13b. MOTHER'S MAIDEN NAME Lena Goldstein		14. NAME OF HUSBAND OR WIFE Guido Vogel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Dr. Benjamin Vogel	
				ADDRESS 9450 Ladue	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		carcinoma of Rectum			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		Intestinal Obstruction			
Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1574X		

22. I hereby certify that I attended the deceased from July 20, 1950, to Aug 17, 1950, that I last saw the deceased alive on Aug 17, 1950, and that death occurred at 5:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE Harold Freedman MD		(Degree or title)		23b. ADDRESS 634 No. Grand Blvd.		23c. DATE SIGNED Aug 13 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/13/50		24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	

DATE REC'D BY LOCAL REG. AUG 13 1950		REGISTRAR'S SIGNATURE L. B. Jasany		25. FUNERAL DIRECTOR'S SIGNATURE Wayne		ADDRESS 4356 Lindell Blvd	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT 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 Me

working under my personal supervision.

Student Embalmer No.....

Signed W. W. Wilkinson

Signed.....
Student Embalmer

Licensed Embalmer No. 3575

P. O. Address St Louis 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.