

FILED MAY 1 1944
Registration District No. 577

Primary Registration District No. 6076

Registrar's No. 986

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans' Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Apr. 20, 1944
(Specify whether years, months or days)
In this community Since April 20, 1944

3. (a) PRINT FULL NAME FOGLE, John S.
3. (b) If veteran, name war W.W. #1
3. (c) Social Security No. 494-05-6034

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive - - years

7. Birth date of deceased October 30, 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>5</u>	<u>25</u>	hr. <u>-</u> min. <u>-</u>

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

10. Usual occupation Brick yard Wheeler

11. Industry or business - -

MOTHER FATHER
12. Name Joe Fogle
13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Henrietta Walker
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schellig Cl. Clk.

(b) Address Vets. Adm. Fac., Jeff. Brks., Mo.

17. (a) Removal (b) Date thereof 4-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville, Mo.
K. B. Wells

18. (a) Signature of funeral director [Signature]
(b) Address Wellsville, Mo.

19. (a) APR 26 1944 (b) C. G. McSavran, MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town Wellsville
(If outside city or town limits, write "RURAL")
(d) Street No. 111 Krekel 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 April day 25th,
year 1944 hour 8:15 PM. minute - M.

21. I hereby certify that I attended the deceased from April 20, 1944 to April 25, 1944; that I last saw him alive on April 25, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death HYPERTENSIVE AND CORONARY ATTERIOSCLEROTIC HEART DISEASE, CARDIAC ENLARGEMENT, MYOCARDIAL DAM-
AGED AGE AND INSUFFICIENCY. UNKNOWN

Due to - -
Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation
Of autopsy No autopsy. 93rd

PHYSICIAN
Underline the cause to which death should be caused statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(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? [Signature] (Specify type of place)
23. Signature L. M. COCHRAN, LT. COL. M.C. (M.D. or other)
Address Chief Medical Officer Date signed 4-26-44

WRITE PLAINLY—USE UNFADING INK

APR 2 1944

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 Self

Registered Apprentice No. _____

working under my personal supervision.

Signed, _____

Licensed Embalmer No. 1588

P. O. Address Hellsville W

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.