

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32391

State File No. \_\_\_\_\_

FILED SEP 21 1953

BIRTH NO. \_\_\_\_\_

REG. DIST. NO. 209

PRIMARY REG. DIST. NO. 3043

Registrar's No. 317

1. PLACE OF DEATH a. COUNTY <b>MARION</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MARION</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>HANNIBAL</b>		c. LENGTH OF STAY (In this place) <b>24 hrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>HANNIBAL</b> <b>0644</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. ELIZABETH HOSPITAL</b>				d. STREET ADDRESS (If rural, give location) <b>623 NORTH BRIDGE ST.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b> b. (Middle) <b>WESLEY</b> c. (Last) <b>FOGLE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>9-1-53</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>MARCH 30, 1886</b>			
9. AGE (In years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>LOUISIANA MISSOURI</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13a. FATHER'S NAME <b>JOE W. FOGLE</b>			13b. MOTHER'S MAIDEN NAME <b>ARMINDA SEWARD</b>			14. NAME OF HUSBAND OR WIFE <b>ROSA BELLE FOGLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>JOHN FRANKLIN FOGLE</b> ADDRESS <b>HANNIBAL, MO 1323 VESPER</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary fibrosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Emphysema &amp; bronchial asthma</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Conjunctive heart failure</b>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>241X</b>				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 checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>8/30/53</b> , 19 <b>53</b> , to <b>9-1</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>9-1</b> , 19 <b>53</b> , and that death occurred at <b>11:25</b> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Richard M. Strong, M.D.</b>				23b. ADDRESS <b>115 N 5th St Hannibal Mo</b>		23c. DATE SIGNED <b>9-4-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>9-4-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>HANNIBAL, MISSOURI</b>			
DATE REC'D BY LOCAL REG. <b>9/10/53</b>		REGISTRAR'S SIGNATURE <b>W E Lucke</b> <b>189</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Schwartz - Hannibal, Mo.</b> ADDRESS _____					

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 17 1952

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED SEP 17 1952

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Jack A. R. Schwartz

Licensed Embalmer No. 4900

P. O. Address Hannibal, 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.