DEC 26 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

35968

1. PLACE OF DEATH

County *Barry* Registration District No. *29* File No.

Township *Flatcreek* Primary Registration District No. *5638* Registered No. *53*

City *Cassville* (No. St. Ward)

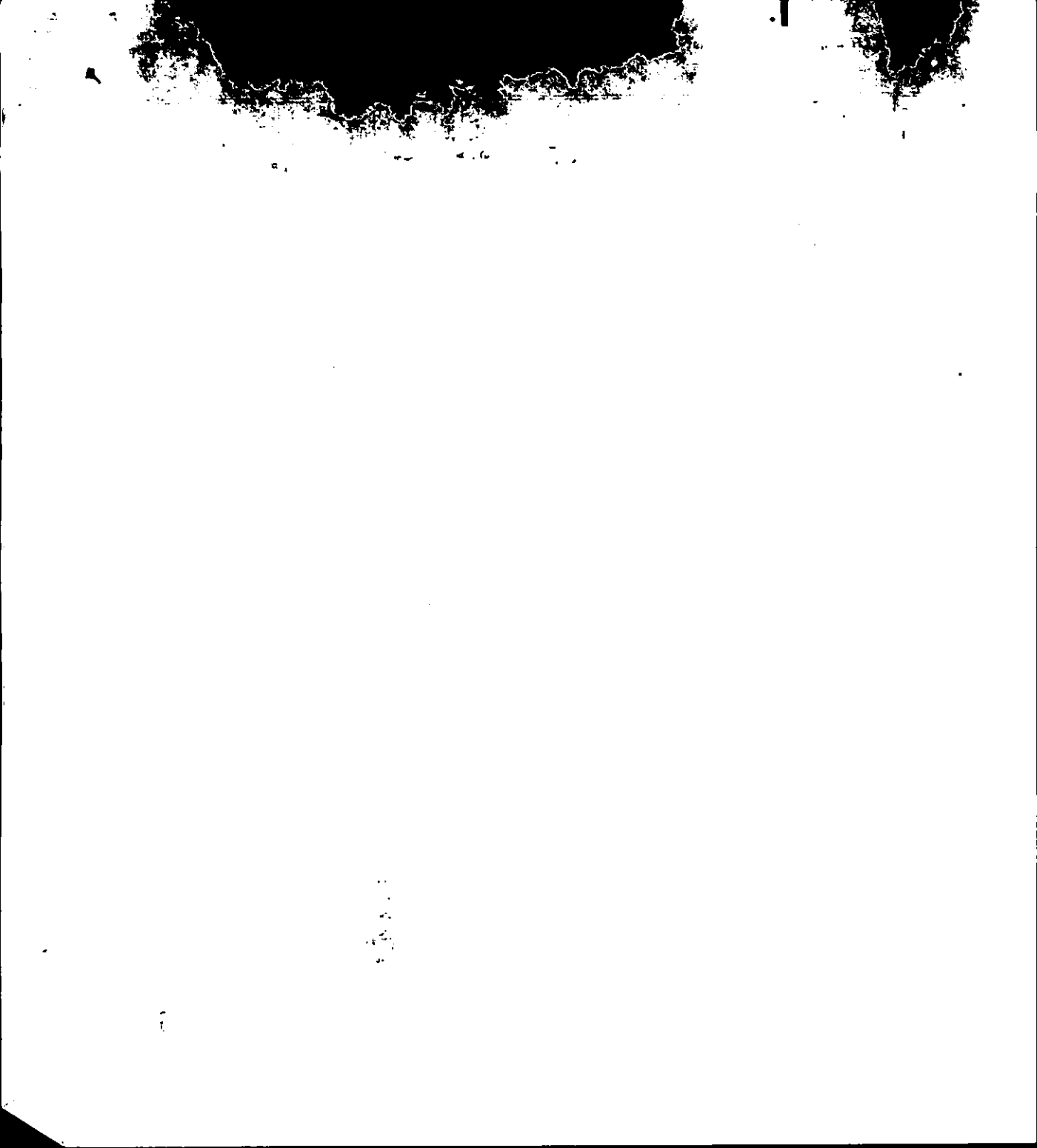
2. FULL NAME *Rachel Jane Fogg*

(a) Residence. No. St., Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3. SEX: *Fe*	16. DATE OF DEATH (month, day and year) *Nov 9th* 19*28*
4. COLOR OR RACE: *White*	17. I HEREBY CERTIFY, That I attended deceased from *at time for past* 19 *six month* 19 that I last saw h*er* alive on *Nov 5* 19*28*, and that death occurred, on the date stated above, at ... m.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): *Widow*	THE CAUSE OF DEATH* WAS AS FOLLOWS: *Probable Cancer of bowels*
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Wm Fogg*	*46c* *45* (duration) *Cant say* yrs. mos. ds.
6. DATE OF BIRTH (month, day and year): *Jan 22 1862*	CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
7. AGE: Years *65* Months *9* Days *17*; If LESS than 1 day, ... hrs. or ... min.	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? *Dont Know*
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Housewife*	*0* DID AN OPERATION PRECEDE DEATH? *no* DATE OF *—*
(b) General nature of industry, business, or establishment in which employed (or employer)	WAS THERE AN AUTOPSY? *no*
(c) Name of employer	WHAT TEST CONFIRMED DIAGNOSIS? *none*
9. BIRTHPLACE (city or town) (State or country) *Indiana*	(Signed) *S. W. Chandler* M.D.
PARENTS 10. NAME OF FATHER *James Dodson*	, 19 (Address) *Cassville Mo*
11. BIRTHPLACE OF FATHER (city or town) (State or country) *Indiana*	*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal.
12. MAIDEN NAME OF MOTHER *Nancy Slavin*	19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Corinth* — DATE OF BURIAL *Nov 10* 19*28*
13. BIRTHPLACE OF MOTHER (city or town) (State or country) *Indiana*	20. UNDERTAKER *Horine Funeral Service* — ADDRESS *Cassville Mo*
14. INFORMANT *James Fogg* (Address) *Cassville, Mo*	
15. FILED *Dec* 19*28* *Mrs N. R. Williams Dpt.* REGISTRAR	

N. B. ... should state ... is very important. ... em of information should be ... CAUSE OF DEATH in plain terms, so that ...



PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOT RECEIVE A F

REG

LAW

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Barry Registration District No. 29 File No.

Township Flat Creek Primary Registration District No. 5038 Registered No. 53

City (No. St. Ward)

2. FULL NAME Rachel Jane Fogg

(a) Residence. No. St., Ward (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Wid

If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22- 1862

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	66	9	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED July 1. 1929 Mrs H. R. Williams Dep't. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 9- 1928

17. I HEREBY CERTIFY, That I attended deceased from ...., 19.... to ...., 19...., that I last saw h.... alive on ...., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ...., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

5-35968