

THE STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **8051**

FILED MAR 19 1949

Registration District No. **120**

Primary Registration District No. **2000**

Registrar's No. **244**

1. PLACE OF DEATH: **GREENE**
 (a) County **Greene**
 (b) City or town **Springfield**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. John's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 1/2 hrs.**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Wright**
 (c) City or town **MT. Grove** "rural"
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Route 6**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **John Wesley Fogerson**
 3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No.**

4. Sex **Male** 5. Color or race **W**
 6. (a) Single, widowed, married **Unmarried**
 6. (b) Name of husband or wife **Infant**
 6. (c) Age of husband or wife if alive **Infant**
 7. Birth date of deceased **March 13, 1949**
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
 If less than one day **8 hr. 30 min.**

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

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER, FATHER
 12. Name **Albert Austin Fogerson**
 13. Birthplace **MT. Grove Mo.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Iva Lucille Julian**
 15. Birthplace **Rayborn Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Albert A. Fogerson**
 (b) Address **Rt. 6 mtn. Lake, Mo.**

17. (a) **Burial** (b) Date thereof **3/14/49**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Pease Cemetery**

18. (a) Signature of funeral director **R.W. Barber**
 (b) Address **Mtn. Home, Mo.**

19. (a) **3/17/49** (b) **M.S. Handley MD**
 (Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **March** day **13**
 year **1949** hour **2** minute **55 PM.**
 21. I hereby certify that I attended the deceased from **3-13-49**
 _____, 19____, to **3-13-**, 19____
 that I last saw him alive on **3-13-**, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death **Atelectasis**
 Due to **Prolonged labor & difficult delivery**
 Due to _____
 Other conditions **None**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations **None**
 Of autopsy **Not done**

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?

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature **J. P. Ferguson** (M. D. _____)
 Address **Springfield, Mo.** Date signed **3-13-49**

WRITE PLAINLY—USE 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

R. W. Barber

Licensed Embalmer No.....

3848

P. O. Address.....

11th Ave, 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.