

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-014034**

**FILED VS. MAY 9 1960**

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 126

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Adair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> Length of stay in 1b <u>12 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K. O. Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scotland</u> c. CITY OR TOWN <u>Memphis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Claude Chesterfield Fogle</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May 1, 1960</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5/10/1881</u>	<b>9. AGE (last birthday)</b> <u>78</u>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Lancaster, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>	
<b>13a. FATHER'S NAME</b> <u>Christopher C. Fogle</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Dorothy Chilress</u>			<b>14. NAME OF HUSBAND OR WIFE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> Address <u>480 Woodview Dr. Pensacola, Fla.</u> <u>Claudie Fogle</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia &amp; shock</u> DUE TO (b) <u>Chronic bowel obstruction</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 weeks</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)						<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <u>4-18-60</u> to <u>5-1-60</u> and last saw him alive on <u>5-1-60</u> Death occurred at <u>10:50 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>MD Chester A. Fogle</u>				<b>22b. ADDRESS</b> <u>Kirksville Mo</u>		<b>22c. DATE SIGNED</b> <u>5-3-60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>May 3, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lancaster Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Lancaster, Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Gerth &amp; Beckett Memphis Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>5-5-1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Dore W. Ratliff</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. T. GUTEN SOHN, D.O.

STATEMENT BY LICENSED EMBALMER

MAY 10 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed George Gerth

Licensed Embalmer No. 524

P. O. Address Memphis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.