

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

=60-033806

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 552 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>10 days</u>	c. CITY OR TOWN <u>Wellsville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>414 KREKLE ST</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>Fogle</u> Last <u>Fogle</u>	4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1960</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-07</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SURGICAL supply in Hosp</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>	11. BIRTHPLACE (City and state or country) <u>Wellsville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joe Fogle</u>	13b. MOTHER'S MAIDEN NAME <u>WALKER</u>	14. NAME OF HUSBAND OR WIFE <u>  </u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>HOSPITAL RECORDS</u> Address <u>  </u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriole Nephrosclerosis</u>	
	DUE TO (c) <u>  </u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given PART I (a) <u>Duodenal Ulceration</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>  </u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>  </u>	COUNTY <u>  </u>	STATE <u>  </u>
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21. I attended the deceased from 9-20-60 to 9-30-60 and last saw her/him alive on 9-30-60  
Death occurred at 8:25 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>Thomas Gordon M.D.</u>	22b. ADDRESS <u>University Hospital</u>	22c. DATE SIGNED <u>9-30-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/30/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>  </u>	23d. LOCATION (City, town, or county) (State) <u>Wellsville, Mo.</u>
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24. FUNERAL DIRECTOR <u>Lynnan Sprinkle</u> ADDRESS <u>Columbia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 30, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 23 1963

OCT 4 1960

OCT 24 1960

**STATEMENT BY LICENSED EMBALMER**

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 A. Tramm*

Licensed Embalmer No. 4425

P. O. Address Columbia

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.