

Dr. Taylor  
**FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-035769**

FILED VS SEP 23 1960, 92

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Ralls</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ralls</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	c. CITY OR TOWN <b>New London</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R #3</b> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>H.</b> Last <b>Fogle</b>			4. DATE OF DEATH Month <b>9</b> Day <b>19</b> Year <b>1960</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Saverton, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Edward Fogle</b>	13b. MOTHER'S MAIDEN NAME <b>Ada West</b>	14. NAME OF HUSBAND OR WIFE <b>U June E. Bell Fogle</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown)   (If yes, give year or dates of service) <b>Yes WW# 1</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. June Fogle R#3, New London</b>	Address
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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) <b>Carcinoma of left lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ a.m. _____ p.m. Month, Day, Year _____
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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 <b>Quincy, Illinois</b>	COUNTY	STATE
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21. I attended the deceased from **7-18-60** to **9-19-60** and last saw him alive on **9-12-60**  
 Death occurred at **12:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>9-20-60 Kent W Barber</b> (Degree or title)	22b. ADDRESS <b>Quincy Clinic - Quincy, Illinois</b>	22c. DATE SIGNED <b>9-20-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/22/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery Quincy, Illinois</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <b>H. M. O'Donnell, Hannibal, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9/21/1960</b>	26. REGISTRAR'S SIGNATURE <b>Colgate C. Wilkey</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 27 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 *A M O'Connell*

Licensed Embalmer No. 3889

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.