

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

33173
-62-021923
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 363

FILED JUL 2 1962

VS 300
Rev. 4/59

1 0109
2 0109
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5 1
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9 581.0
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13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>4 yrs.</u>	c. CITY OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1209 Porter Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clay</u> Middle <u>Gillespie</u> Last <u>Fogg</u>			4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1883</u>
9. AGE (last birthday) <u>79</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>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Montgomery County, Kent.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Thomas I. Fogg</u>	
13b. MOTHER'S MAIDEN NAME <u>Katherine Gillespie</u>		14. NAME OF HUSBAND OR WIFE <u>Katherine Fogg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>Mrs. Charles Cline Columbia, Mo.</u> Address <u> </u>
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>Corporosis of liver</u> <u>portal hypertension</u> <u>abdominal ascites 2 mo.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>			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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>			
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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>May 1 at 62</u> to <u>June 26</u> and last saw <u>him</u> alive on <u>June 25 at 62</u> Death occurred at <u>5:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James M. Baker MD</u>		22b. ADDRESS <u>Columbia, Mo.</u>	22c. DATE SIGNED <u>June 27, 1962</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/28/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u>
24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u>	ADDRESS <u>Columbia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 28, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Lynian Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbia, MD

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.