WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County

Township or Village or City St Louis (NO. 1610 Hogan St.; 4 Ward)

Registration District No. 781 File No. 36002

Primary Registration District No. 1003 Registered No. 8952

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Wm Foley

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: ~~January~~ Dec. (Month) 25 (Day), 1854 (Year)

AGE: Fifty six yrs. 6 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Team Owner
(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Vans

BIRTHPLACE (City or town, State or foreign country): County Kerry Ireland

PARENTS
NAME OF FATHER: James Foley
BIRTHPLACE OF FATHER (City or town, State or foreign country): County Kerry
MAIDEN NAME OF MOTHER: Mary Shea
BIRTHPLACE OF MOTHER (City or town, State or foreign country): County Kerry

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tim J Foley

(ADDRESS) 1610 Hogan Str

Filed NOV 15 1910, 191 H. Wheeler Bond REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

DATE OF DEATH: Nov (Month) 14th (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1st, 1910, to Nov 14th, 1910, that I last saw him alive on Nov 10th, 1910, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic rheumatism

57B

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ~~Senile Deb~~ Debility

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) C. G. Rohlfing M. D.

Nov 15th, 1910 (Address) 1827 Cass Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Calvary

DATE OF BURIAL: Nov 17, 1910

UNDERTAKER: Harrigan Shafer

ADDRESS: 2614 Morgan

United States Standard Certificate of Death

d by U. S. Census and American Public Health Association]

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it of occupation.—Precise statement of oc- very important, so that the relative health- various pursuits can be known. The ques- to each and every person, irrespective of nany occupations a single word or term on e will be sufficient, e. g., *Farmer* or *Planter, Compositor, Architect, Locomotive engineer, eer, Stationary fireman,* etc. But in many ially in industrial employments, it is neces- ow (*a*) the kind of work and also (*b*) the the business or industry, and therefore an ine is provided for the latter statement; it ised only when needed. As examples: (*a*)) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery; an,* (*b*) *Automobile factory.* The material may form part of the second statement. urn "Laborer," "Foreman," "Manager," etc., without more precise specification, as *r, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

HUGH STEPHENS, JEFFERSON CITY.