

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.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42066

Registration District No.

Primary Registration District No.

Registrar's No. 11189

1. PLACE OF DEATH: 1000

(a) County 1

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days
(Specify whether years, months or days)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3819 Sherman Pl.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Jane Foley U S W

3. (b) If veteran, name war No. _____

3. (c) Social Security No. No.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas Foley 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Aug. 19th. 1855
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

84 4 9 hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Willys Bayless

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. L. Taylor

(b) Address 3819 Sherman Pl.

17. (a) Burial (b) Date thereof 12-30-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director W. Leidner, Und. Co.

(b) Address 1413 1/2 Market St.

19. (a) DEC 29 1939 (b) J. D. Bauder
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 28,
year 1939 hour 3:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from December 22, 1939 to December 28, 1939
and that death occurred on the date and hour stated above.

that I last saw h er alive on _____
Immediate cause of death Broncho Pneumonia Duration 6 day

Due to _____

Due to _____

Other conditions arteriosclerotic Heart Disease _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy as above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Walter T Ford (M. D. or other) _____

Address 1515 Lafayette Date signed 12/28/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis

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 this body is not embalmed, above space should be left blank.