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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27591

State File No. 3225

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
(Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2847 Jarboe
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME MRS. MARY T. FOLEY

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased February 6, 1857
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 6 If less than one day
hr. _____ min.

9. Birthplace Worn County, New Jersey
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Michael Connell

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

14. Maiden name Julia Hogan

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

16. (a) Informant Elmer J. Foley

(b) Address 3221 Barnes Blvd.

17. (a) Burial (b) Date thereof 8/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director Thos J. Foley

(b) Address 741 E. 1st

19. (a) Aug. 15, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 12
year 40 hour 11 minute P M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of right femur
Due to Bum Chapman's
Due to Fall in his own home

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

Major findings: _____
Of operations _____

Of autopsy Autopsy

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

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 8/12/40

(c) Where did injury occur 2847 Jarboe (City or town) (County) (State)

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

While at work? No (Specify type of place) (e) Means of injury Fall

23. Signature M. M. Crowe (M. D. or other)

Address _____ Date signed 8/13/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *Charles M. Dennis*

Licensed Embalmer No. *3774*

P. O. Address *Kansas City, 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 this body is not embalmed, fact should be so stated above.