

No. 2
1-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29715

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1642

1. PLACE OF DEATH:

(a) County St. Charles Louis County
(b) City or town St. Louis, MO. Melator
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Vincent's Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 days
(Specify whether
In this community 22 days
years, months or days)

3. (a) PRINT FULL NAME MRS. NORA FOLEY 400

3. (b) If veteran, name war No.
3. (c) Social Security No. No.

4. Sex F. 5. Color or race W.
6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife PHILIP FOLEY
6. (c) Age of husband or wife if alive 17 years (Day) (Year)

7. Birth date of deceased DEC 17 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 11
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name JERRY O'CONNOR

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

14. Maiden name MARGARET E HAN

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

16. (a) Informant MRS KATHERINE HELGE

(b) Address 624 N. 22ND E. ST. LOUIS ILL

17. (a) BURIAL (b) Date thereof 8-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. CARMEL CEM. BELLEVILLE ILL

18. (a) Signature of funeral director NELL WALSH BARNES

(b) Address 1416 ST. LOUIS AVE ESTL. ILL.

19. (a) AUG 28 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County ST. CLAIR
(c) City or town EAST ST. LOUIS ILL.
(If outside city or town limits, write "RURAL")
(d) Street No. 624 North 27th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 60 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28th
year 1940 hour 8 a.m. minute a.m.

21. I hereby certify that I attended the deceased from August 6th
1940 to Aug. 28th 1940
that I last saw h. RR. alive on AUGUST 27 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arterio-sclerosis 5 years
Generalized arterio-sclerosis
Due to cardio-renal-vascular disease 5 years
Due to _____
Other conditions Senility
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

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) None

(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? _____

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

23. Signature W. B. Pytton (M. D. or other) 1
Address St. Vincent's Sanitarium Signed _____

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 *Albert G. Hoppe*

Licensed Embalmer No. *2971*

P. O. Address.....

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.

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