Form No. 200
Rev. 10.48

FILED MAY 27 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17988

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4156

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Missouri Pac. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): University City 4366
d. STREET ADDRESS (If rural, give location): 1263- 82nd Street

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) c. (Last) FOLEY
4. DATE OF DEATH (Month) (Day) (Year): 5-2-52
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 8-15-1889
9. AGE (In years last birthday): 62 — If under 1 year: Months, Days; If under 1 day: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired engineer
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and State or Foreign Country): New York
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: William Foley
13b. MOTHER'S MAIDEN NAME: unknwon
14. NAME OF HUSBAND OR WIFE: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: James Foley, ADDRESS: 1263-82nd Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cerebral Apoplexy
DUE TO (c) Gastro-malacia

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 3451

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 3:51 p.m., from the causes and on the date stated above.*

23a. SIGNATURE: Patrick E. Taylor Coroner (Degree or title)
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 5-3-52

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 5-5-52
24c. NAME OF CEMETERY OR CREMATORY: Resurrection
24d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

DATE REC'D BY LOCAL REG.: MAY 3 1952
REGISTRAR'S SIGNATURE: J. Earl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Al C. Ortmann, Overland, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed [illegible]

Licensed Embalmer No. 3478

P. O. Address [illegible] 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.