

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 26 1960

-60-029084  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 2049

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maplewood</b>		Length of stay in 1b <b>5 Months</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Maplewood Nursing Home</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2344 Benton St.</b>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>L.</b> Last <b>FOY</b>			4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1960</b>			
--	--	--	---	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1879</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Handler-Ely Walker Dry Goods Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
--	--	-----------------------------------	--	---	--	--	--

13a. FATHER'S NAME <b>Albert Foy</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Kelly</b>		14. NAME OF HUSBAND OR WIFE <b>Late Ella Foy</b>	
---	--	---	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-03-8422A</b>		17. INFORMANT Address <b>Mrs. Loretta O'Connor 5750 Oleatha Ave.</b>	
---	--	--	--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>over 6 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
---	--	--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
---	---	--	--	--	--

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
--	--	--	--	--	--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
--	--	------------------------------	--	--------	-------

21. I attended the deceased from **Feb 6, 1960** to **July 6, 1960** and last saw him alive on **July 6, 1960**.  
Death occurred at **9:00 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>James B. Jones M.D.</b>		22b. ADDRESS <b>9313 Manchester St. Louis 19 Mo.</b>		22c. DATE SIGNED <b>7-7-60</b>	
--	--	---	--	-----------------------------------	--

23a. BURIAL (Cremation, Removal) (Specify) <b>Removal</b>	23b. DATE <b>July 8, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
--	----------------------------------	---	--	--	--

24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>7-7-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
--	--	---	---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R.W. Storesand

Licensed Embalmer No. 2007

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.