

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

25204

1. PLACE OF DEATH

County..... Registration District No. **701**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. 1717 Missouri Ave

File No.....
 Registered No. **6998**
 St. Ward)

2. FULL NAME Francis B. Foley Jr.

(a) Residence. No..... St., 23 Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 14 1928</u>		
7. AGE YEARS	MONTHS	DAYS
XXXXXXX	1	10
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>none</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>St. Louis</u> (STATE OR COUNTRY) <u>Mo.</u>		
PARENTS	10. NAME OF FATHER <u>Francis B. Foley Sr.</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Omaha</u> (STATE OR COUNTRY) <u>Neb.</u>	
	12. MAIDEN NAME OF MOTHER <u>Georgia Lohenberg</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>	
14. INFORMANT <u>Francis B. Foley Sr.</u> (Address) <u>1717 Missouri Ave.</u>		
15. FILED <u>JUL -5 1928</u> REGISTRAR <u>W. Starkley</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-4 1928

17. I HEREBY CERTIFY, That I attended deceased from 6-26-28 to 7-4-28 that I last saw h.i.v. alive on 7-4-28, and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suffocation - due to blood clots in each nostril

CONTRIBUTORY (SECONDARY) 180

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? no DATE OF.....
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? no
 (Signed) Raymond Robertson, M.D.
 , 19 (Address) 718 Beaumont Med Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Oak Grove Cemetery</u>	DATE OF BURIAL <u>July 5, 1928</u>
20. UNDERTAKER <u>McLaughlin</u>	ADDRESS <u>1631 Desmarais</u>

COPY WITH OUPPING INK--THIS IS A PERMANENT RECORD

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.

