

APR 28 1936 30634-a

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

Do not use this space.

30634 a

1. PLACE OF DEATH

County *Henry Co*

Registration District No. *14*

Township *Windsor*

Primary Registration District No. *421*

City *Windsor* (No. *1*)

File No. *16*

Registered No. *16*

St. *Mo.* Ward *1*

2. FULL NAME

*Ann Foley*

(a) Residence. No. *1* St. *Mo.* Ward *1*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Female*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*married*

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

*John F. Foley*

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*Oct 12 1866*

7. AGE

*62*

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

*Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

*Putnam County, Mo.*

10. NAME OF FATHER

*Leopold J. Foley*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Howard County, Mo.*

12. MAIDEN NAME OF MOTHER

*unmarried*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Marion County, Mo.*

14.

INFORMANT

(Address)

*John F. Foley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

*Sept 17 1929*

17.

I HEREBY CERTIFY, That I attended deceased from

*Sept 17 1929* to *Sept 17 1929* that I last saw him alive on *Sept 13 1929* and the death occurred, on the date stated above, at *1340* p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*falling operation for the removal of fibrous tissue called suspensory ligament of bladder*

CONTRIBUTORY (SECONDARY)

*obstructed bladder*

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

*at home*

IF NOT AT PLACE OF DEATH...

DID AN OPERATION PRECEDE DEATH?

*Yes* DATE OF *Sept 13 1929*

WAS THERE AN AUTOPSY?

*No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

*J. C. Woodruff*

, 19

(Address)

\*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

*Bethlehem Near Marshall Missouri*

DATE OF BURIAL

*Sept. 18-1929*

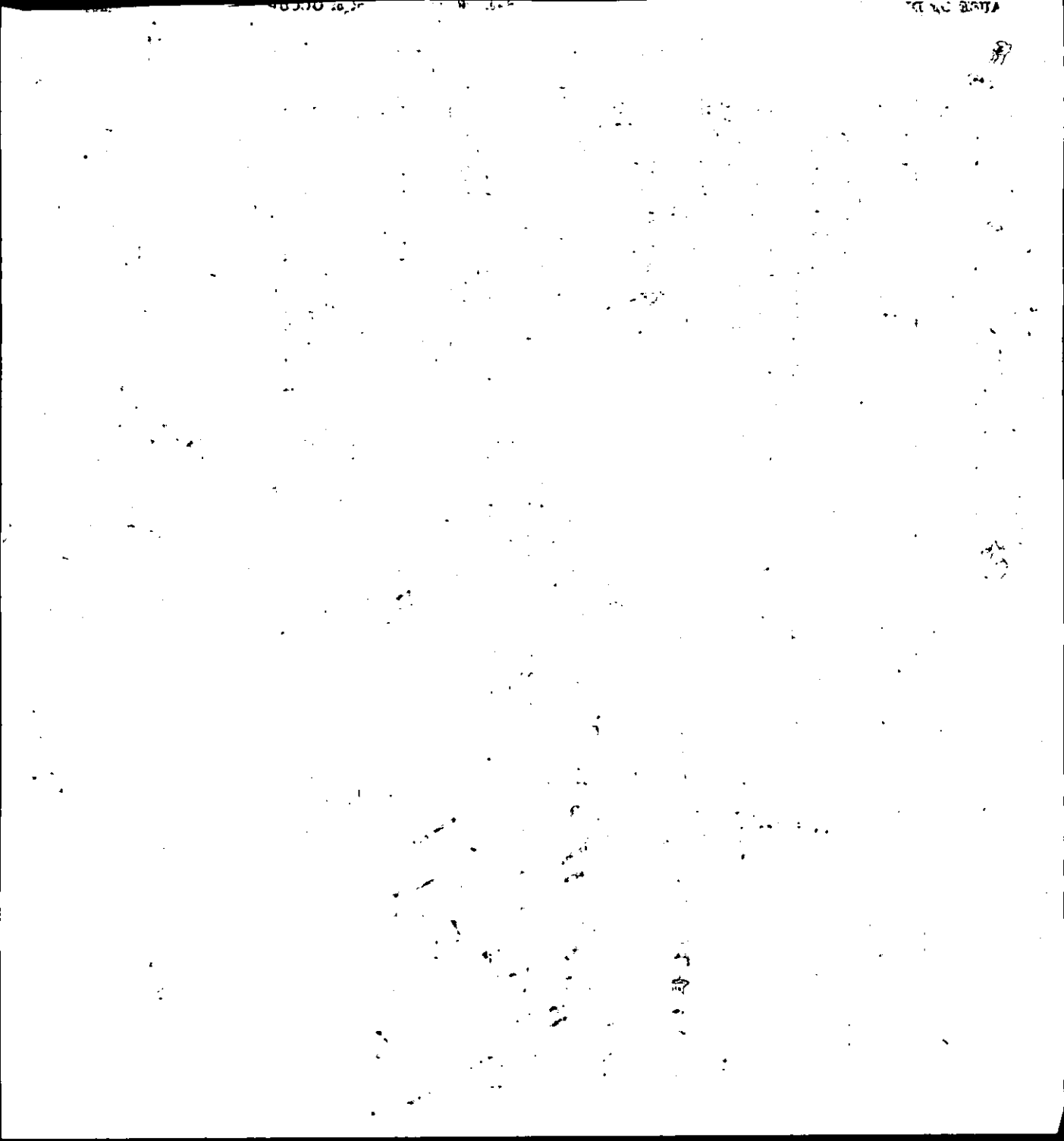
20. UNDERTAKER

*L. A. Roof*

ADDRESS

*Windsor Mo.*

FILED *15* 19 *29* *J. J. Deming* REGISTRAR



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

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Henry  
 Township Windsor  
 City Windsor (No. ....)

Registration District No. 14  
 Primary Registration District No. 4211

File No. ....  
 Registered No. 16  
 St. .... Ward)

**2. FULL NAME**

Ann Foley

(a) Residence. No. .... St. .... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 12 - 1866

7. AGE YEARS 62 MONTHS X DAYS X IF LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. 18 29 11 Dennings REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1929

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h. .... alone on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Substern operation for the removal of  
breast tumor  
not malignant  
 (duration) .... yrs. .... mos. .... ds.  
 CONTRIBUTORY (SECONDARY) Obstruction of bowel  
 (duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....  
 WAS THERE AN AUTOPSY?  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) ..... M. D.  
 , 19 (Address)

\*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 DATE OF BURIAL

UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1929

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