

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

Do not use this space.

30802

1. PLACE OF DEATH U.S. VET. HOSP., K.C. Missouri.

County JACKSON

Registration District No. 399

File No. _____

Township Law

Primary Registration District No. _____

Registered No. 3825

City KANSAS CITY

(No. 21 D Veterans Hosp)

St. _____ Ward _____

2. FULL NAME FOLEY, Peter Clarence

WOE C-1,227,588

(a) Residence. No. Missouri City, Missouri, St.

Ward Pvt. Co. A, 356th Inf.

(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 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) June 18, 1891

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	38	2	21	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer _____

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

10. NAME OF FATHER Unknown.

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

12. MAIDEN NAME OF MOTHER Unknown.

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

14. INFORMANT HOSPITAL RECORDS,
 (Address) U.S. VETERANS' HOSPITAL,

Kansas City, Missouri.

FILED 9/10 19 29 M. M. Larson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 9, 1929.

17. I HEREBY CERTIFY, That I attended deceased from December 15, 1928 to September 9, 1929, that I last saw him alive on September 9, 1929, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia.
10 A
1000
 (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) _____
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

3 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 8-29-29.

WAS THERE AN AUTOPSY? Yes.

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy.

(Signed) W. E. Chalbers, M. D.
9/10 W. E. CHALBERS, Medical Officer in Chge,
U.S. VETERANS' HOSPITAL, Kansas City,
Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Missouri City Missouri DATE OF BURIAL Sept 11 1929

20. UNDERTAKER The Taylor Funeral Home Inc. ADDRESS Kansas City Missouri

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.

WRITE MAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

