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

Do not use this space.

37229

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 4699
Township Kaw — Primary Registration District No. 1002 — Registered No.
City K 6 Mo (No. 2847 Jarboe St. Ward)

2. FULL NAME Thomas Foley
(a) Residence. No. 2847 Jarboe St., 3 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: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mrs Mary Foley

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unk 1846

7. AGE: 83 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Grocer
(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): Indiana

PARENTS
10. NAME OF FATHER: Patrick Foley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Harriett Dorsey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland

14. INFORMANT: Elmer Foley
(Address) 3221 Karnes Blvd

15. FILED 11-16, 1929 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 11-15 1929

17. I HEREBY CERTIFY, That I attended deceased from 11-15, 1929, to 11-15, 1929, that I last saw him alive on 11-15, 1929, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Myocarditis, Chronic
(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (SECONDARY): Enteritis
(duration) yrs. mos. 2 ds.

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? Clinical
(Signed) A. J. Wilt, M. D
11/18, 1929 (Address) 835 Rialto

*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: St Marys — DATE OF BURIAL: 11/18 1929

20. UNDERTAKER: Quirk & Toben — ADDRESS: K 6 Mo

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.