

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 2847 Jarboe)

Registration District No. 399
Primary Registration District No. 1002

File No. 23019
Registered No. 3011
St. _____ Ward _____

2. FULL NAME William A 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

Male

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

Mary B Foley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 5 1882

7. AGE

47

YEARS

MONTHS

7

DAYS

16

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Produce Salesman

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

(c) Name of employer Creamery Co.

9. BIRTHPLACE (CITY OR TOWN) Edina

(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Thomas L Foley

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

12. MAIDEN NAME OF MOTHER Mary T Connell

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

14. INFORMANT E J Foley
(Address) Kansas City Mo

15. FILED 7/27 19 30 M M Cross REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21 1930¹⁹

17. I HEREBY CERTIFY, That I attended deceased from 7-12
1930, to 7-21 1930
that I last saw him alive on 7-21, 1930, and that death occurred, on the date stated above, at 12:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia, lobar

CONTRIBUTORY (SECONDARY)

10/10 (duration) yrs. mos. 9 ds.
10/10 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Agnes Lech M. D.

7/27 19 30 (Address) 235 Rault

*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' Cemetery

DATE OF BURIAL

7/23/30¹⁹

20. UNDERTAKER

Quirk & Tobin--20 W Linwood

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.

