

MAY 10 1938

 MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH
791  
1008

13154

Do not use this space.

## T. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No..... Registered No. **3496**  
 or St. Louis, Missouri (c) City Sanitarium St.  
 (c) City No. 65 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

400 Margaret Foley  
 Little Sisters of the Poor St. 20 2209 Hebert  
 (a) Residence, No. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	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 Single		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-30-1873		
7. AGE YEARS 65	MONTHS 3	DAYS 15
If LESS than 1 day, ..... hrs. or ..... min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework	11. Total time (years) spent in this occupation.
	9. Industry or business in which work was done, as saw mill, bank, etc. Domestic	
	10. Date deceased last worked at this occupation (month and year) 1-25	
12. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri		
FATHER	13. NAME John Foley	14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ireland
	15. MAIDEN NAME Catherine McKinney	
MOTHER	16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Nebraska	
	17. INFORMANT H.C. Gehrand, M.D. (ADDRESS) 5400 Arsenal St	
18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE April 17th, 1938		
19. FUNERAL DIRECTOR (NAME) Stroot - Carroll (ADDRESS) 4600 Natural Bridge Ave		
20. FILED APR 15 1938 J.F. Bricker Local Registrar.		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-14-39 . 19

22. I HEREBY CERTIFY, That I attended deceased from 7-1-38 19. to 4-14-49 19. I last saw her alive on 4-14-39 19. Death is said to have occurred on the date stated above, at 11:50 P.M. The principal cause of death and related causes of importance were as follows:  
 Senility 7-1-38  
 1538  
 Other contributory causes of importance:  
 Decubitus Ulcers 1-30-39x  
 Date of onset

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury..... 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify.....  
 (Signed) Henry B. Gehrand, M.D.  
 (Address) 5300 Arsenal.

(Licensed Embalmer's Statement on Reverse Side)

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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision: .

Signed: *Edward H. Stewart*

Licensed Embalmer No. *2265*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**