

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis Missouri Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mt. St. Rose Hospital D  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 mos 26 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Foley

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased UNK. 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 UNKNOWN hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Martin Madden  
13. Birthplace 4 Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Carroll  
15. Birthplace 4 Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant James E. Carroll

(b) Address 322 S. Gore Ave. (Welsh Grove)

17. (a) Burial (b) Date thereof 2-28-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CATHYARY

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3640 Levee Blvd.

19. (a) FEB 27 1941 (b) J.R. Meyer M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis MO  
(c) City or town St. Louis Mo 19  
(If outside city or town limits, write "RURAL")  
(d) Street No. 9101 So Broadway  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26  
year 1941 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from 7-27-40  
\_\_\_\_\_, 19\_\_\_\_, to 2-26, 1941;  
that I last saw her alive on 2-26, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Far advanced Pulmonary Tuberculosis Duration 2 1/2 yrs

Due to \_\_\_\_\_  
Due to 13  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy none

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature G. E. Lerman M.D. (M. D. or other) 0  
Address Mt. St. Rose Sanatorium Date signed 2-27-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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

*Stanley Marshall*

Licensed Embalmer No.

*2868*

P. O. Address

*3840 Lindell*

**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.**