

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kan City mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5200 Highland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 25 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Foley

(b) If veteran, name war 3. (c) Social Security No.

4. Sex fe 5. Color or race w 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 8, 1861 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 7 hr. min.

9. Birthplace Indianapolis (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Maurice Mulvihill
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Catherine Quillen
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mary Foley
(b) Address 211 W 20th St Terrace

17. (a) (b) Date thereof 4/17/41 (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cem

18. (a) Signature of funeral director Roy E Brown

(b) Address 2315 Lombard

19. (a) Apr 16, 1941 (b) M. Crowe (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kan City Mo (If outside city or town limits, write "RURAL")
(d) Street No. 5200 Highland (If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from Feb 1 April 12, 1941, to April 15, 1941; that I last saw her alive on April 12, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 1-2 days

Due to Hypertensive heart dis year

Due to arteriosclerosis year

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

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 John T. Sherman (M. D. or other) MD
Address 11462 Bryant Bay Date signed 4-16-41

D. Skinner

1402

Bryant

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.....

Ray E. Snow

Licensed Embalmer No. *2560*

P. O. Address *1507 E 29*

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, fact should be so stated above.