

S. No. 2
FORM-2-43
5-17-39
I X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23837**
Registrar's No. **3225**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution **General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2mo 2 days**
In this community **15 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **624 Campbell**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Margaret Foley**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **23**
year **1943** hour **2** minute **30** A. M.
21. I hereby certify that I attended the deceased from **May 21** to **July 23** 19 **43**
that I last saw her alive on **July 23** 19 **43**
and that death occurred on the date and hour stated above.

4. Sex **Fe** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **John J Foley**
6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **No Record**
(Month) (Day) (Year)

Immediate cause of death **CARCINOMA OF THE BREAST WITH EXTENSION TO THE MEDIASTINUM**
Due to **50**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy **see above**

8. AGE: Years Months Days If less than one day
Approx 49 years
9. Birthplace **Wexford** **Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**
11. Industry or business
12. Name **No record**
13. Birthplace **No record** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **No record**
15. Birthplace **No record** **9**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **John J Foley**
(b) Address **624 Campbell**
17. (a) **Burial** (b) Date thereof **7-26-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Mary's**
18. (a) Signature of funeral director **J. W. Wagner**
(b) Address **Kansas City Mo.**
19. (a) **7-24-43** (b) **P. E. Brown**
(Date received local registrar) (Registrar's signature)

23. Signature **Wm. R. Johnson**
Address **Med. Dir. K.C. General Hospital**
Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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

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..... *A. R. Hunschuld*.....

Licensed Embalmer No. *4159*.....

P. O. Address *Kansas City Mo*.....

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.