

32857

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 20 1944

Registration District No. 1318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

29315

State File No.

Registrar's No. 7962

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 6 days
 (Specify whether
 In this community 0
 years, months or days)

3. (a) PRINT
FULL NAMEMartin Foley3. (b) If veteran,
name war _____

3. (c) Social Security

No 494-26-5259

4. Sex 0 Male 5. Color or race White
 6. (a) Single, widowed, married, divorced 2 Widowed

6. (b) Name of husband or wife Elizabeth
6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased 7 12 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>2</u>	<u>4</u>	hr. _____ min. _____

9. Birthplace _____
(City, town, or county) (State or foreign country)10. Usual occupation Retired

11. Industry or business _____

12. Name Martin Foley13. Birthplace Ireland
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Margaret Foley(b) Address Fairgrounds Hotel17. (a) Burial (b) Date thereof 9-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Calvary Cemetery18. (a) Signature of funeral director Sullivan Funeral Dir(b) Address 2849 North Euclid Ave19. (a) SEP 17 1944 (b) J. J. Buehler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2826 No. Jefferson
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16th
year 1944 hour 6 minute 45 A. M.21. I hereby certify that I attended the deceased from 8/10/44
19____, to Sept. 16th, 1944that I last saw him alive on Sept. 16th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

carcinoma of floor of
mouth with neckDue to metastases

Due to _____

Other conditions _____

Major findings:
Of operations noneOf autopsy none

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)

23. Signature D. J. Verda (M. D. or other)
Address 1515 Lafayette Date signed 9/16/44

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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 *Eugene A. Sullivan*
Licensed Embalmer No. *2930*

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. OCRegistrar's No. 7962Registration District No. 318Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County.....
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution.....
-
- (Specify whether

In this community.....
years, months or days)3. (a) PRINT FULL NAME Martin Foley

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

4. Sex m 5. Color or race w
 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased July 12 1914
 (Month) (Day) (Year)

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

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

10. Usual occupation Retired

11. Industry or business.....

12. Name.....
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....
 17. (a) (Burial, cremation, or removal) (b) Date thereof.....
 (Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
 (b) Address.....

19. (a) OCT 5 1914
 (Date received local registrar) (Registrar's signature) J. F. Bredich

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No.....
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12
 year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
 that I last saw him..... alive on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

- Due to.....
 Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

- Major findings:
 Of operations.....
 Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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..... (M. D. or other).....
 Address..... Date signed.....

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

MOTHER FATHER

29315