

U. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

4714

FILED DEC 1 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3227 Benton Blvd
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 20 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City Missouri 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 3227 Benton Blvd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Miss Margaret Ellen FOLEY

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 24 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 9 28 _____ hr. _____ min.

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

10. Usual occupation Retired
11. Industry or business Practical Nurse

MOTHER FATHER

12. Name John Foley
13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Dean
15. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Crahan
(b) Address 3227 Benton Blvd
17. (a) Burial (b) Date thereof 11-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Melody-McGilley
(b) Address Kansas City Missouri

19. (a) 11-23-44 (b) M. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22nd
year 1944 hour 5:15 minute P. M.

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

Immediate cause of death _____ Duration _____
Cerebral Hemorrhage
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Inspection & history
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?

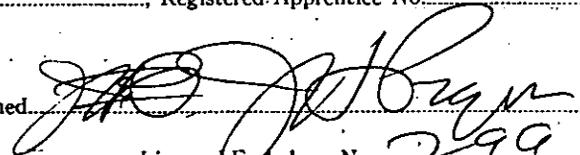
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature A. E. Washburn (M. D. or other) _____
Address 128 McCoy Date signed 11/23/44

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.....



Licensed Embalmer No..... 2999

P. O. Address..... ICC

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.