S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21908

State File No. .....

FILED JUL 30 1945

Registration District No. 318 Primary Registration District No. 200 Registrar's No. 6070

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: DePaul Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-days (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St.Louis 96

(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")

(d) Street No. 470 E.Lockwood Ave. NR. 7
(If rural, give location) 4

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Sister Isabella Marie Foley

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

4. Sex F. 1 5. Color or race W. 6. (a) Single, widowed, married, divorced S 0

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

7. Birth date of deceased Oct.13th., 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	18	29	..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Religious

11. Industry or business .....

FATHER
12. Name John G.Foley
13. Birthplace ..... (City, town, or county) Ireland 11 (State or foreign country)

MOTHER
14. Maiden name Mary E.Mollineux
15. Birthplace ..... (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Sister Matthew Marie
(b) Address Webster College

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) JUL 13 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1945 hour 11 minute 30 9 M.

21. I hereby certify that I attended the deceased from Oct 5 37 to July 12, 1945
that I last saw her alive on July 12, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	10 Days
Due to Myocardial Infarct	10 Days
Due to Hypertension Heart Disease	3 Yrs
Other conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	1 Yr

Major findings:
Of operations —
Of autopsy .....

61

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 [signature] (M. D. or other) 7-14-45
Address 607 No Grand Date signed 7/12

(Licensed Embalmer's Statement on Reverse Side)

Dr. [redacted]
Univ. Club Bldg.

1-3

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, fact should be so stated above.