No. 2
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5-17-39
X25697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25634

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7888

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

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:
5515 Devonshire 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ccc
(c) City or town St. Louis 1714
(If outside city or town limits, write "RURAL")
(d) Street No. 5515 Devonshire 9
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dolores Foley
3. (b) If veteran, name war
3. (c) Social Security No.
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 JAN (Month) 22 (Day) 1914 (Year)

8. AGE:

Years	Months	Days	If less than one day
31	7	15	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name Edward A. Foley
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Ruth Mulick
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Ruth Foley
(b) Address 5515 Devonshire
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Cullen & Kelly
(b) Address 4386 Lindell
19. (a) SEP (Date received local registrar) (b) J F Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 9/25/44
9/25 1944 to 9/7 1945
that I last saw her alive on 9/7/45 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Massive pulmonary hemorrhage	15 min.
Due to: Bilateral far advanced pulm tuberculosis active	18 mos.
Due to:	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations: none
Of autopsy: none

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) none
(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 John J Hammond (M.D. or other) M.D.
Address 684 N. Grand Date signed 9/8/45

(Licensed Embalmer's Statement on Reverse Side)

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. .....

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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25634

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7488

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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Dolores Foley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 22 (Day) 1914 (Year)

8. AGE: Years 31 Months 7 Days If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) 9-19-45 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

1945
S-25634