

No. 300  
10-48

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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34461

State File No. ....

FILED OCT 2 1953

BIRTH NO. .... REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 542 Registrar's No. 25410

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Ferguson</b>	c. LENGTH OF STAY (In this place) <b>2 yrs.</b>	c. CITY OR TOWN <b>Ferguson</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>25 Airport Rd.</b>		e. STREET ADDRESS (If rural, give location) <b>25 Airport Rd.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Johanna</b> b. (Middle) <b>--</b> c. (Last) <b>Foley</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 13, 1953</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 28, 1873</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Ireland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
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13a. FATHER'S NAME <b>Patrick Quirk</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Hill</b>	14. NAME OF HUSBAND OR WIFE <b>John Foley</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>John Foley, Ferguson, Mo.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean (the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive heart failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arterio sclerotic heart disease</b> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>  <b>many years</b>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Sept 10, 1952**, to **13 Sept, 1952**, that I last saw the deceased alive on **13 Sept, 1952**, and that death occurred at **3:30A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Thomas E Kuebeck M.D.</b>	23b. ADDRESS <b>95. Flouissant Rd Ferguson Mo</b>	23c. DATE SIGNED <b>9/14/53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>9/15/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>9/14/53</b>	REGISTRAR'S SIGNATURE <b>Herbert R. ...</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>White Chapel, Ferguson, Mo.</b>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Eleana Province*

Licensed Embalmer No. *340*

P. O. Address *Jennings*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.