

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23705

FILED JUL 25 1956

State File No. \_\_\_\_\_  
Registrar's No. 2935

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		State File No. _____		Registrar's No. <u>2935</u>					
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>									
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>33 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		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 <u>St. Lukes Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>5631 Wayne</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>NORA</u>			b. (Middle) _____			c. (Last) <u>FOLEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 4 1956</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, 1. WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1889</u>		9. AGE (in years last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Nicholasville, Kentucky</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>John W. Cooper</u>				13b. MOTHER'S MAIDEN NAME <u>Kathryn O'Connell</u>				14. NAME OF HUSBAND OR WIFE <u>John J. Foley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>496-24-7853A</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John J. Foley</u> ADDRESS <u>5631 Wayne</u>							
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Constrictive Heart Failure</u> ANTECEDENT CAUSES DUE TO (b) <u>Pulmonary Infection</u> DUE TO (c) <u>Atrial Fibrillation (n-m-o)</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH          <u>4331</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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) _____							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____									
22. I hereby certify that I attended the deceased from <u>9-3-1955</u> to <u>7-4-1956</u> , that I last saw the deceased alive on <u>7-4-1956</u> , and that death occurred at <u>2:45 p.m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE <u>Robert K. Skillman M.D.</u> (Degree or title) _____						23b. ADDRESS <u>4635 Wyandotte, Kansas City, Mo.</u>			23c. DATE SIGNED <u>7-5-56</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-7-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				24d. LOCATION (City, town, or county) (State) <u>Hickman Mills, Missouri</u>					
DATE REC'D BY LOCAL REG. <u>7-6-56</u>		REGISTRAR'S SIGNATURE <u>Neva Minshall</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Melody-McGilley-Eylar</u> ADDRESS <u>1800 E. Linwood</u>							

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

Dr. Robert Skilton  
4635 Wagonwheel  
Jan 1-5-63  
all left-hand

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 *James E. Hackler*.....  
Licensed Embalmer No. *4573*.....

P. O. Address *Kansas City*.....

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.