

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 31 1957

State File No. **26099**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6889**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Oklahoma b. COUNTY Garfield			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo		c. LENGTH OF STAY (in this place) 21 days		c. CITY OR TOWN Enid	
d. FULL NAME OF HOSPITAL OR INSTITUTION 41 Frisco Employes Hospital Assn		e. STREET ADDRESS (If rural, give location) 33 215 West Walnut			
3. NAME OF DECEASED (Type or Print) a. (First) Pete		b. (Middle)		c. (Last) Foley	
4. DATE OF DEATH (Month) (Day) (Year) 7 21 57		5. SEX <input type="radio"/> Male <input type="radio"/> Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH August 17, 1892		9. AGE (In years last birthday) 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bridge Builder		10b. KIND OF BUSINESS OR INDUSTRY Rail-road		11. BIRTHPLACE (City and State or Foreign Country) Taloga, Oklahoma.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Tim Foley		13b. MOTHER'S MAIDEN NAME Amanda Poland	
14. NAME OF HUSBAND OR WIFE Cressie Foley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. #1. 702-07-8288	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Cressie Foley, 215 W. Walnut, Enid, Okla.					

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Posterior Medialstinitis with Separation of Esophageal Gastro Anastomosis		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease Generalized Arteriosclerosis				10 mos	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Duodenal Ulcer Pyloric Obstruction Complete					
19a. DATE OF OPERATION 10/22/56		19b. MAJOR FINDINGS OF OPERATION Stenosis Distal Esophagus				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) W. W.		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 **10/1/56** to **7/21**, 19**57**, that I last saw the deceased alive on **7/21**, 19**57**, and that death occurred at **7:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) Carl Smith M.D.		23b. ADDRESS 4960 Laclede St. Louis, Mo		23c. DATE SIGNED 7/22/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-22-57		24c. NAME OF CEMETERY OR CREMATORY Local	
24d. LOCATION (City, town, or county) (State) Watonga, Oklahoma.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 1700 Washington Blvd.,			
DATE REC'D BY LOCAL REG. JUL 23 57		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			

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

Vertical writing: *Vertical writing Hello, MD.*

m. g. B.

(Licensed Embalmer's Statement on Reverse Side)

JUL 31 1957

SEP 27 1957

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 *G. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *Albany*

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.