

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35801  
STATE FILE NUMBER

FILED NOV 14 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5022

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4028 Park</b>		Length of stay in lb <b>39 yrs.</b>	d. STREET ADDRESS <b>4028 Park</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna M. Foley</b>			4. DATE OF DEATH Month Day Year <b>10 - 29 - 57</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 - 7 - 1883</b>	9. AGE (In years last birthday) <b>74</b>	10. FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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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 country) <b>Hugo Colorado</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Malia</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Finan</b>	14. NAME OF HUSBAND OR WIFE <b>Stephen E. 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>493-12-3730</b>	17. INFORMANT <b>Stephen E. Foley</b>	Address <b>4028 Park K.C. Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>331 X</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>Jan 19 50</b> to <b>Oct 29 57</b> and last saw her/him alive on <b>Oct 29 - 1957</b> Death occurred at <b>8:30 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>H. H. Owens M.D.</b> (Degree or title)	22b. ADDRESS <b>1034 Quail Blv</b>	22c. DATE SIGNED <b>10-29-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-31-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) <b>Hickman Mills Missouri</b>
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24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar</b>	ADDRESS <b>1800 E. Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>10-29-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

H. H. Owens

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



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 *J. H. Pryor* .....  
Licensed Embalmer No. 2999 .....  
P. O. Address NC Mo .....

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.