

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44347
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5697

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		Length of stay in lb 39 yrs.	
STREET ADDRESS 4535 Olive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter M. Foley Sr.			4. DATE OF DEATH Month Day Year 12 1 57
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1881
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor	11. BIRTHPLACE (City and state or country) Topeka, Kansas
10a. KIND OF BUSINESS OR INDUSTRY Coal Industry		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Foley		13b. MOTHER'S MAIDEN NAME Alice Waters	
14. NAME OF HUSBAND OR WIFE Ella Foley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 487-07-1708		17. INFORMANT Address Ella Foley 4535 Olive KCMO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senescence, atherosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) Rupture of heart DUE TO (c) Acute myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 6 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 Kansas City Jackson Mo	
21. I attended the deceased from 1955 to 12/1/57 and last saw ^{her} him alive on 12/1/57 - Death occurred at 6:00 p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. B. McGinnill (Degree or title)		22b. ADDRESS 836 Ogden Blvd	
22c. DATE SIGNED 12/2/57		22d. ADDRESS 836 Ogden Blvd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-4-57	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR ADDRESS Melody-McGillee-Eylar KCMO.		25. DATE RECD. BY LOCAL REG. 12-2-57	
26. REGISTRAR'S SIGNATURE neva Minshall			

Mr. Faley

Dr. V. T. Williams

KP 2

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 W. Weir*

Licensed Embalmer No. *4650*

P. O. Address *HC Mr*

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.