

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS NOV 3 1959**

**2 9700** **59-037591**  
 REGISTRATION DISTRICT NO. \_\_\_\_\_ PRIMARY REGISTRATION DISTRICT NO. \_\_\_\_\_ REGISTRAR'S NO. \_\_\_\_\_ STATE FILE NUMBER

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                         |  | Length of stay in 1b   | c. CITY OR TOWN <b>St. Louis, Mo.</b>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Incarnate Word Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   | d. STREET ADDRESS (If outside, give location)<br><b>1651 Spring Ave.</b>              |
|   |  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                              |   |  |  |
|--|------------------------------|---|--|--|
| 3. NAME OF DECEASED<br>(Type or print) <b>Nora Foley</b>   |                              |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>22nd.</b> Year <b>1959</b> |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-29-1868</b>                                      | 9. AGE (last birthday)<br><b>90</b>        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired, Cleaning Worker</b> |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bd. of Education</b>  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>        | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b> |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 13a. FATHER'S NAME<br><b>John Foley</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Prendergast</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>Single</b>                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>None</b>               |  | 17. INFORMANT<br><b>Miss Mary Ann Getty</b> Address <b>1651 S. Spring</b> |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10/15/59</b><br><b>10/22</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                                    |  | <b>420.0</b>  |

|   |  |   |
|---|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|---|

|   |   |  |  |
|---|---|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>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.) |  |
| 20c. TIME OF INJURY. Hour _____ a.m. _____ p.m. Month, Day, Year _____                            |   |  |  |

|  |  |                              |        |       |
|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <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 |
| 21. I attended the deceased from <b>10/15</b> to <b>10/22</b> and last saw her/him alive on <b>10/22</b> .<br>Death occurred at <b>1:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |                              |        |       |

|  |                                |   |  |  |
|--|--------------------------------|---|--|--|
| 22a. SIGNATURE<br><b>Ralph Berg md</b> (Degree or title)   |                                | 22b. ADDRESS<br><b>3203 S Grand</b>                           |  | 22c. DATE SIGNED<br><b>10/24/59</b>                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>10-24-1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |

|   |  |  |  |
|---|--|--|--|
| 24. FUNERAL DIRECTOR<br><b>Arthur J. Donnelly</b> ADDRESS <b>3840 Lindell Blvd.</b> |  | 25. DATE RECD. BY LOCAL REG.<br><b>OCT 23 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith, M.D.</b> |
|---|--|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

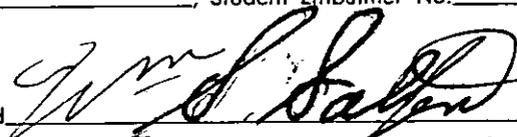
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address 3840 Lind

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.