

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 10 1960

-60-035297

STATE FILE NUMBER

Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 109

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| 1. PLACE OF DEATH a. COUNTY JEFFERSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL-MERAMEC | Length of stay in 1b 33 DAYS | c. CITY OR TOWN St. Louis | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp Intermar | | d. STREET ADDRESS (If outside, give location) 5 GREEN ACRES | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or print) First MORGAN Middle P. Last FOLEY | | | 4. DATE OF DEATH Month SEPT. Day 19 Year 1960 | | | |
| 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 10/26/1900 | 9. AGE (last birthday) 59 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY Merchant - Paint Co. | | 11. BIRTHPLACE (City and state or country) Boston, Mass | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |

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|-----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|-------------------------------------------------------------|--|
| 13a. FATHER'S NAME John Foley | | 13b. MOTHER'S MAIDEN NAME FLAHERTY, Catherine | | 14. NAME OF HUSBAND OR WIFE Viola CAMPBELL 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. 494-03-3921 | | 17. INFORMANT Do. Ruth St. Joseph's Hosp Intermar | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH 5 DAYS |
| IMMEDIATE CAUSE (a) | CARDIAC DECOMPENSATION | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | BRONCHIO PNEUMONIA | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) OLD CEREBROVASCULAR ACCIDENT; GEN. ARTERIOSCLEROSIS | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | | |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------|---------------------|
| 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 St. Louis | COUNTY Mo. | STATE Mo. |
| 21. I attended the deceased from Aug. 17th 1960 to 9/19/1960 and last saw her/him alive on 9/16/1960 . Death occurred at 12:35 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 21a. SIGNATURE (Degree or title) Patrick C. Hagen M.D. | | 21b. ADDRESS 2623 Telegraph Rd Kenay 25 Mo. | | 21c. DATE SIGNED 9/21/60. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 9/22/60 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) St. Louis | (State) Mo. |
| 24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd. | | 25. DATE RECD. BY LOCAL REG. 9-22-60 | 26. REGISTRAR'S SIGNATURE Robert E. Bauer | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 ET 180

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address A. J. ...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.