

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

22496

1. PLACE OF DEATH

County Ray
Township Crooked River
City _____ (No. _____)

Registration District No. 740
Primary Registration District No. 4442
5975-

File No. 1
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geahella Foye

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 2nd 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 7 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Va. Hardy

13. NAME Samuel Foye

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

15. MAIDEN NAME Mary Hannah Heisk

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

17. INFORMANT (ADDRESS) Wm Foye

18. BURIAL, CREMATION, OR REMOVAL PLACE Wakenda Cem DATE June 26 1931

19. UNDERTAKER (ADDRESS) Jno W. Kupsch

20. FILED June 25th 1931 B. L. Willeford Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 25 1931

22. I HEREBY CERTIFY That I attended deceased from April 28 1931 to June 21 1931
I last saw him alive on June 21 1931. Death is said to have occurred on the date stated above, at 9 A. m.

The principal cause of death and related causes of importance were as follows:

Endocarditis

Date of onset

92B 92B

Other contributory causes of importance:

Nausea

Name of operation Chloroform Date of _____

What test confirmed diagnosis? Chloroform Was there an autopsy? _____

23. If death due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 1931

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) W. P. DeGruy M. D.

(Address) Worwood Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 28 1931

