

No. 2
M-5-43
v. 5-17-39
I X38871

FILED SEP 30 1948

State File No. _____
Registrar's No. 1081

Registration District No. _____ Primary Registration District No. 1000

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Weeks
(Specify whether)
 In this community 36 Years
years, months or days)

3. (a) PRINT FULL NAME Josephine Pecora
 3. (b) If veteran, name war None
 3. (c) Social Security No. 491-10-0698

4. Sex Female
 5. Color or race Italian
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Charles
 6. (c) Age of husband or wife if alive * years
 7. Birth date of deceased April 22 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>5</u>	<u>1</u>	_____ hr. _____ min.

9. Birthplace Unknown Italy
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER {
 12. Name Salvatore Mussemecchi
 13. Birthplace Unknown Italy 5
(City, town, or county) (State or foreign country)
 14. Maiden name Angela Ballistra
 15. Birthplace Unknown Italy 5
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Angelo Pecora
 (b) Address 1520 Francis St.
 (c) Burial (b) Date thereof Sept. 25, 48
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herbert W. S. ...
 (b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Sept. 26, 1948 F. J. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan //
 (c) City or town St. Joseph //
(If outside city or town limits, write "RURAL")
 (d) Street No. 1009 Mitchell Ave. //
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country *

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23
 year 1948 hour 9 minute 35 A.M.

21. I hereby certify that I attended the deceased from July 3
1946 to Sept 23 1946
 that I last saw her alive on Apr 23 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Auricular Fibrillation</u>	<u>3 mos.</u>
<u>Diabetes mellitus</u>	<u>13 years</u>
Due to _____	
Due to _____	
Other conditions <u>Post-operative Thyrotoxicosis</u> <u>5 day</u> <small>(Include pregnancy within 3 months of death)</small>	

PHYSICIAN _____

Major findings:
 Of operations 6382
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature F. J. ... (M. D. or other) mo
 Address 216 Phoebe & Long Bldg Date signed 9-24-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

28459

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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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Shirley Thomas

Licensed Embalmer No. 2640

P. O. Address St Joseph 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 this body is not embalmed, fact should be so stated above.