

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004610

STATE FILE NUMBER

177

Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> <u>303 E</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>		Length of stay in lb <u>8 years</u>	d. STREET ADDRESS (If outside, give location) <u>700 E. 5th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSE POLEZZI</u>			4. DATE OF DEATH Month Day Year <u>Feb. 16, 1958</u> 1959		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Sicily</u>		12. CITIZEN OF WHAT COUNTRY? <u>Sicily?</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Joe Polezzi (Polizzi) deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Records</u> Address <u>State Hospital # 2 St. Joseph, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <u>Fracture Right Hip</u>					<u>Oct. 1958</u>
DUE TO (c) <u>90.57</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Patient fell on the ward and fractured right hip</u>			
20c. TIME OF INJURY Hour Month Day Year a.m. <u>Oct. 1958</u> p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>On ward, State Hospital #2</u>	20f. CITY, TOWN, OR LOCATION <u>St. Joseph, Mo.</u>	COUNTY <u>Buchanan</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>February 4, 1959</u> to <u>February 16, 59</u> and last saw her <u>alive</u> on <u>February 16, 1959</u> Death occurred at <u>9:40 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Mohammad Tahr M.D.</u>			22b. ADDRESS <u>State Hospital # 2 St. Joseph, Mo.</u>		22c. DATE SIGNED <u>Feb. 16, 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Feb. 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kirksvill College</u>		23d. LOCATION (City, town, or county) (State) <u>Kirkville, Mo.</u>	
24. FUNERAL DIRECTOR <u>Clark Funeral Home</u>		ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 17, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>	

BY AFFIDAVIT OF PRACTICE
USE ONLY BLACK INK OR RIBBON TYPE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
Dr. Mohammad Tahr

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 *Eric A. Smith*

Licensed Embalmer No. 1228

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.