

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED DEC 20 1943

318

Primary Registration District No. 1003

Registrar's No. 11228

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Louis City Hospital,  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 Days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 96  
(d) Street No. 1400a Purd Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Frank Albert Polizzi

MEDICAL CERTIFICATION

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month December day 17,  
year 1943 hour 3:45 minute A. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, single

21. I hereby certify that I attended the deceased from November 28, 1943, to December 17, 1943,  
that I last saw him alive on December 17, 1943,  
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 13 1943  
(Month) (Day) (Year)

Immediate cause of death Influenzal Meningitis 2 1/2 weeks

8. AGE:	Years	Months	Days	If less than one day
	<u>4</u>		<u>4</u>	_____ hr. _____ min.

Due to \_\_\_\_\_

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

10. Usual occupation none

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

MOTHER FATHER { 12. Name Sam Polizzi  
13. Birthplace unk 7  
(City, town, or county) (State or foreign country)

Of autopsy Influenzal Meningitis Brain abscess

MOTHER FATHER { 14. Maiden name Osbar  
15. Birthplace unk 9  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Sam Polizzi  
(b) Address 1400a Purd av

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof Dec. 20-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

(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? \_\_\_\_\_

18. (a) Signature of funeral director P. Miceli-Son  
(b) Address 115 0 N. Kingshighway

While at work \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature: J. F. Madoc or other \_\_\_\_\_  
Address: 1515 Lafayette Avenue, St. Louis 12/17/43

19. (a) DEC 18 1943 (b) J. F. Madoc  
(Date received local registrar) (Registrar's signature)

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

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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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.**