

WHITE PAPER! - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

FILED APR 10 1944

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 272

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:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 hour & 15 Min.
(Specify whether
 In this community 34 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11
 (c) City or town St. Joseph 7
(If outside city or town limits, write "RURAL")
 (d) Street No. 919 Seneca
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Carmela Folise

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, 2 divorced Widowed
 6. (b) Name of husband or wife Nicholas Folise 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 22 1875
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Sicily Italy 5
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Francis Paul Fulca

13. Birthplace Sicily Italy 5
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Capizi

15. Birthplace Sicily Italy 5
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. William A. Folise

(b) Address 2920 Miller Ave.

17. (a) Burial (b) Date thereof 3-14-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Norman W. Sidenfaden

(b) Address 1802 Union, St. Joseph, Mo.

19. (a) 3-14-44 (b) Rose Herzog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
 year 1944 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from March 6 1944 to March 11 1944
 that I last saw her alive on March 11 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis general
arteriosclerotic heart disease

Due to _____

Due to _____

Other condition Portiac. Dacryopneumonia today
(Include pregnancy within 3 months of death)

Major findings: Of operations 93d

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature R. J. Senior M.D. (M. D. or other) 0

Address St. Joseph, Mo. Date signed 3-13-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

1233

Handwritten signature

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 Robert H Reed

Licensed Embalmer No. 3745

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.