

S. No. 2
M-5-43
v. 5-17-39
I X36671

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Keokuk**

(c) Name of hospital or institution:
St Joseph's Hosp.

(d) Length of stay: In hospital or institution. **4 weeks**

In this community **4 1/2 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

(c) City or town **Keokuk**

(d) Street No. **2829 E 8th**

(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **JOE FALCO**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **500-03-4223**

4. Sex **M.O** **5. Color or race** **W.**

6. (a) Single, widowed, married, divorced **M!**

6. (b) Name of husband or wife **Mary**

6. (c) Age of husband or wife if alive **unk.**

7. Birth date of deceased **Mar 26 1889**

8. AGE: Years **58** Months **4** Days **7**

If less than one day **Italy 5**

9. Birthplace **Italy 5**

10. Usual occupation **Fareman**

11. Industry or business **Maintenance**

12. Name **Guippe Falco**

13. Birthplace **Italy 5**

14. Maiden name **Giuseppa Giribasi**

15. Birthplace **Italy 5**

16. (a) Informant **Mrs Tommie Semone**

(b) Address **414 Walnut**

17. (a) Burial **(b) Date thereof** **7/15/47**

(c) Place: burial or cremation **Mt St Mary's**

18. (a) Signature of funeral director **Sebbetosi**

(b) Address **City**

19. (a) 7-4-47 (b) Geraldine Holmes

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **3** year **47** hour **9:00** minute **A** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw _____ alive on _____, 19____, and that death occurred at the date and hour stated above.

Immediate cause of death: **Chr. Myocardial Infarction**

Due to **Coronary Occlusion**

Due to **Coronary Occlusion**

Other conditions: _____

Major findings: **932**

Of operations: _____

Of autopsy: **above**

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ Means of injury _____

23. Signature **Dr. J. P. Holmes** **(M.D. or other)**

Address **St Joseph's Hospital** **Date signed** **July 12**

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

MOTHER, FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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..... *Ray E Snow*
Licensed Embalmer No. *2560*
P. O. Address..... *R E M*

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.