

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12536**
Registrar's No. **37**

FILED MAY 11 1954

BIRTH NO. _____ REG. DIST. NO. **174** PRIMARY REG. DIST. NO. **3035**

1. PLACE OF DEATH a. COUNTY Lafayette			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lafayette		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		c. LENGTH OF STAY (In this place) 10 YEARS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		0542
d. FULL NAME OF HOSPITAL OR INSTITUTION 1611 Bloom St.			d. STREET ADDRESS (If rural, give location) 1611 Bloom St.		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Maddeline	b. (Middle) N.	c. (Last) Polla	Date (Month) (Day) (Year)	April 23, 1954	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 8, 1893	9. AGE (In years last birthday)	10. MONTHS	11. DAYS	12. IF UNDER 1 YEAR	13. IF UNDER 24 HOURS	14. MIN.
61	2	15							

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and State or Foreign Country) Brusnengo, Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
---	--	--	--	---	--	---	--

13a. FATHER'S NAME Joseph Giorza		13b. MOTHER'S MAIDEN NAME Caroline Giorza		14. NAME OF HUSBAND OR WIFE In Vecoli Polla Lexington	
--	--	---	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Iris Giorza, Lexington ? Missouri.		ADDRESS	
---	--	--	--	--	--	---------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage			DUE TO (b) Congestive heart failure				few hours	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			DUE TO (c) Cerebral hemorrhage October 1953.					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	----------------------------------	--	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
--	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
---	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from **4/23/54** to **4/23/54**, that I last saw the deceased alive on **4/23/54**, and that death occurred at **7:40 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ben H. Brasher M.D.		23b. ADDRESS Lexington, Mo.		23c. DATE SIGNED 4/30/54	
--	--	---------------------------------------	--	------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 25, 1954	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Lexington Missouri
--	------------------------------------	--	--

DATE REC'D BY LOCAL REG. 5-6-54	REGISTRAR'S SIGNATURE Wm. E. Catalano	FUNERAL DIRECTOR'S SIGNATURE James T. Lempert	ADDRESS Lexington Missouri
---	---	---	--------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

Brush

MAY 26 1954

MAY 18 1954

MAY 11 9 1954

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
Student Embalmer

Signed *Geo. W. Kean*

Licensed Embalmer No. 2983

P. O. Address *Livingston, Missouri*

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.