

FILED JUN 12 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16227

Registration District No. 949

Primary Registration District No. 1002

Registrar's No. 2346

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

1. PLACE OF DEATH: Jackson

(a) County: Jackson

(b) City or town: Kansas City

(c) Name of hospital or institution: 235 Park Ave B

(d) Length of stay: In hospital or institution: 5 Days

In this community: 5 Days

3. (a) PRINT FULL NAME: Joseph Bottero Sr.

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

3. (c) Social Security No.: Don't know

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife: Lexia Bottero

6. (c) Age of husband or wife if alive: 54 years

7. Birth date of deceased: March 29 1887

8. AGE: 61 Years 2 Months 5 Days

9. Birthplace: Italy

10. Usual occupation: Butcher

11. Industry or business: Butcher

12. Name: Joseph Bottero Sr.

13. Birthplace: Italy

14. Maiden name: Don't know

15. Birthplace: Italy

16. (a) Informant: Lexia Bottero

(b) Address: Frontonac K.S.

17. (a) Removal: (b) Date thereof: June 7 1948

(c) Place: burial or cremation: Frontonac K.S.

18. (a) Signature of funeral director: Passantino Bros

(b) Address: K. C. Mo

19. (a) 6-4-48 (b) Berdine Holmes

2. USUAL RESIDENCE OF DECEASED:

(a) State: Kansas (b) County: 999

(c) City or town: Frontonac K.S. 14

(d) Street No.: 2

(e) Citizen of foreign country? Unknown (Yes or No) 2

If yes, name country:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4

year 1948 hour 12 minute 30 AM

21. I hereby certify that I attended the deceased from June 1 1948 to June 4 1948

that I last saw him alive on June 3 1948

and that death occurred on the date and hour stated above.

Immediate cause of death: acute cardiac failure

Duration: 24 hrs.

Due to: cerebral and mediastinal malignancy (m.m.a.)

Duration: 6 months

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings: 47 f

Of operations:

Of autopsy: (Refused)

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

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?

While at work? (Specify type of place)

Means of injury:

23. Signature: William F. Sanders (M.D. or other)

Address: Research Clinic 23 Holme, T.C. Mo Date signed 6/14/48

Dr. Sanders  
Research Client

JUL 2 1948

**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 \_\_\_\_\_

*Francis Walton*

Licensed Embalmer No. 2744

P. O. Address 12 C. M. O.

**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.**