

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045427

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12648

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1</b>		d. STREET ADDRESS (If outside, give location) <b>2/37, 5225 Patterson Ave.,</b>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUCIAN</b> Middle <b>PAUL</b> Last <b>BITONTI</b>			4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1958</b>
5. SEX <b>Male</b> <input type="radio"/>	6. COLOR OR RACE <b>White</b> <input type="radio"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 16, 1920</b>
9. AGE (In years last birthday) <b>38</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>McDonald Aircraft</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b> <input type="radio"/>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>John Bitonti</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Lombardi</b>	14. NAME OF HUSBAND OR WIFE <b>Reta Bitonti</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>W.W. II</b>		16. SOCIAL SECURITY NO. <b>192-05-9918</b>	17. INFORMANT <b>Reta Bitonti, 5225 Patterson Avenue.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> Conditions, if any, due to (b) <b>Upper Gastrointestinal Hemorrhage</b> Other cause (c) <b>Post Hepatic Cirrhosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>581.0</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>581.0</b>	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>19</b>	20f. CITY, TOWN, OR LOCATION <b>ST. LOUIS</b> COUNTY <b>ST. LOUIS</b> STATE <b>MISSOURI</b>
21. I attended the deceased from <b>12-25-1958</b> to <b>12-26-1958</b> and last saw her alive on <b>12-26-1958</b> Death occurred at <b>5:10 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Joseph J. Szabla</b> (Degree or title) <b>MD</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>12-26-1958</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-29-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Missouri.</b>
24. FUNERAL DIRECTOR <b>Calcaterra Funeral Home, 5110 Daggett Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 30 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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STATE OF MISSISSIPPI

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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 ..... Student Embalmer No. .... working under my personal supervision.

Student .....

Signature of Student Embalmer

Signed *John S. Deunsky* .....

Licensed Embalmer No. *4194* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.