

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028958

FILED VS SEP 4 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3998 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett City</u>		Length of stay in 1b <u>39 yrs</u>		c. CITY OR TOWN <u>Kennett City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>333 Oak</u>				d. STREET ADDRESS (If outside, give location) <u>333 Oak</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>PHILLIP</u> Middle <u>BARTOLOTTA</u> Last <u>BARTOLOTTA</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1959</u>				
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-22-1919</u>		
9. AGE (last birthday) <u>39</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Kennett City, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Dominick Bartolotta</u>				13b. MOTHER'S MAIDEN NAME <u>Hioloma S. Leonard</u>		14. NAME OF HUSBAND OR WIFE <u>Marilyn</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW # 2</u>			16. SOCIAL SECURITY NO. <u>499-10-0769</u>		17. INFORMANT <u>Marilyn Bartolotta</u> Address <u>KCMo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>							<u>4 mos</u>	
DUE TO (b) <u>Cerebral metastases</u>							<u>6 mos</u>	
DUE TO (c) <u>Carcinoma of head of Pancreas</u>							<u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		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.)				
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>						
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>1956</u> to <u>Aug 16, 1959</u> and last saw her alive on <u>Aug 15, 1959</u> Death occurred at <u>6:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Philip Bartolotta</u> (Degree or title)				22b. ADDRESS <u>518 9746 St K.C., Mo</u>		22c. DATE SIGNED <u>8/16/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>8-19-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary Com.</u>		23d. LOCATION (City, town, or county) (State) <u>Kennett City, Mo</u>		
24. GENERAL DIRECTOR <u>Carroll Bess</u> ADDRESS <u>KCMo</u>				25. DATE RECD. BY LOCAL REG. <u>8-18-59</u>		26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

PHILLIP D. REISTER MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr. Charles W. Gargyle, D.D.S.
Dr. Reiche, D.D.S.
Aug 16 1954 - 6:30 AM.*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signature *Ronald Pasantun*

Licensed Embalmer No. 455
P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.