

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-029273  
STATE FILE NUMBER

Primary Registration District No. 1002 Registrar's No. 3832

AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 ITEM NO.  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>57 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		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. Lukes</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1136 Pacific</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Gustie</b> Middle <b>Gargotta</b> Last <b>Gargotta</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1961</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6/9/1904</b>		9. AGE (last birthday) <b>57</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (City and state or country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Joseph Gargotta</b>				13b. MOTHER'S MAIDEN NAME <b>Caroline Nigro</b>				14. NAME OF HUSBAND OR WIFE <b>—</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Rose Gargotta 1136 Pacific</b>							
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) <b>Cerebral Hemorrhage</b>										<b>12 Days.</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <b>Ruptured aneurysm of left communicating artery</b>			
DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>										<b>5 yrs +.</b>			
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 checked="" 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 _____ a.m. _____ p.m.		Month, Day, Year											
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>July 15, 1961</u> to <u>July 31, 61</u> and last saw her alive on <u>July 31, 1961</u> . Death occurred at <u>11:30 AM K. City Mo</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Arnold V. Arms MD</b>						22b. ADDRESS <b>4625 Wyandotte St. City Mo</b>			22c. DATE SIGNED <b>8-1-61.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/3/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>				23d. LOCATION (City, town, or county) <b>Kansas City Mo.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Peter B. Lapetina 536 Campbell</b>				25. DATE RECD. BY LOCAL REG. <b>8-2-61</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>							

**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,

~~embalmer~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Jack J Moore*

Licensed Embalmer No. 4729

P. O. Address K.E. Mc

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.