

NEW YORK STATE  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

RECORDED DISTRICT  
5154  
REGISTER NUMBER  
2062

CENSUS TRACT  
SUB-DIVISION

STATISTICAL DISTRICT  
REC.  
RES.

1 NAME FIRST MIDDLE LAST  
Rudolph F. Martinek  
2 SEX  
MALE  FEMALE   
3A. DATE OF DEATH  
MONTH DAY YEAR  
11 29 85  
3B HOUR  
1:50 P.M.

4 AGE  
IF UNDER 1 YEAR IF UNDER 1 DAY 5. DECEDENT BORN 6 VETERAN OF U.S. ARMED FORCES?  
MONTHS DAYS HOURS MINUTES MONTH DAY YEAR NO YES IF YES, SPECIFY WAR OR DATES OF SERVICE  
73 YEARS 11 8 12   WW 11 7. SOCIAL SECURITY NUMBER  
116-09-6600

8A. COUNTY OF DEATH 8B. LOCALITY (CHECK ONE AND SPECIFY) 8C. HOSPITAL OR OTHER INSTITUTION (IF NEITHER, GIVE ADDRESS) 8D. IF IN HOSPITAL OR INSTITUTION (CHECK ONE) 8E. IF INPATIENT ADMISSION DATE  
 CITY OF  TOWN OF Islip Good Samritan Hos.  D.O.A.  EMERGENCY ROOM  OUTPATIENT  INPATIENT  
MONTH DAY YEAR

9 STATE OF BIRTH (COUNTRY IF NOT USA) 10. CITIZEN OF WHAT COUNTRY? 11. MARITAL STATUS (CHECK ONE) 12. SURVIVING SPOUSE (IF WIFE GIVE MAIDEN NAME)  
New York U.S.A. 1  NEVER MARRIED 3  WIDOWED 2  MARRIED OR SEPARATED 4  DIVORCED Jeanne Kapey

13. RACE WHITE, BLACK, AMERICAN INDIAN, OTHER (SPECIFY) 14. OF SPANISH ORIGIN? IF YES CHECK ONE 15. EDUCATION: INDICATE HIGHEST GRADE COMPLETED ONLY  
White 1  MEXICAN 2  PUERTO RICAN 3  CUBAN 4  CENTRAL OR SOUTH AMERICAN 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17  
ELEMENTARY HIGH SCHOOL COLLEGE  
00 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17

16A. USUAL OCCUPATION (DO NOT ENTER RETIRED) 16B. KIND OF BUSINESS OR INDUSTRY 16C. NAME AND LOCALITY OF FIRM OR COMPANY  
Dentist Dentistry Self-Employed

17A. STATE 17B. COUNTY 17C. LOCALITY (CHECK ONE AND SPECIFY) 17E. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS?  
New York Suffolk Islip YES  NO  IF NO, SPECIFY TOWN:  
17D. STREET AND NUMBER OF RESIDENCE (INCLUDE ZIP CODE) West Islip  
7 Oak Neck Lane 11795

18A. NAME OF FATHER: FIRST MIDDLE LAST 18B. MAIDEN NAME OF MOTHER: FIRST MIDDLE LAST  
Frank Martinek Rose Ann Plisek

18A. NAME OF INFORMANT 19B. MAILING ADDRESS (INCLUDE ZIP CODE)  
Jeanne Martinek 7 Oak Neck Lane West Islip, N.Y. 11795

20A. BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION (SPECIFY) MONTH DAY YEAR 20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION 20C. LOCATION (CITY OR TOWN, STATE)  
Burial 12 2 85 Mt. St. Mary Cemetery Flushing, N.Y.

21A. NAME AND ADDRESS OF FUNERAL HOME 21B. REGISTRATION NO.  
Lang-Tobia-DiPalma F.H. 255 Higbie La. West Islip, NY 03328

22A. NAME OF FUNERAL DIRECTOR 22B. SIGNATURE OF FUNERAL DIRECTOR 22C. REGISTRATION NO.  
Ann Marie Peterson [Signature] 08779

23A. SIGNATURE OF REGISTRAR 23B. DATE FILED 24A. BURIAL OR REMOVAL PERMIT ISSUED BY 24B. MONTH DAY YEAR  
[Signature] Dec 28 85 [Signature] 11 30 85

25. TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY -OR- TO BE COMPLETED BY CORONER OR MEDICAL EXAMINER ONLY

A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED  
SIGNATURE [Signature] 11 29 85

B. THE PHYSICIAN ATTENDED THE DECEASED C. LAST SEEN ALIVE  
FROM: 11 28 85 TO: 11 28 85 C. 11 28 85  
B. PRONOUNCED DEAD C. HOUR D. DATE SIGNED  
ON: AT M. MONTH DAY YEAR

D. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER E. SIGNATURE OF CORONER OR CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER  
[Signature]

26. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, CORONER, MEDICAL EXAMINER, CORONER'S PHYSICIAN, MEDICAL DIRECTOR)  
Howard Hertz, M.D. 350 W. Main St. Babylon, N.Y. 11702

27. DEATH WAS CAUSED BY ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
PART I. IMMEDIATE CAUSE (A) [Handwritten Cause] mins

(B) [Handwritten Cause] (C) [Handwritten Cause]

PART II. OTHER SIGNIFICANT CONDITIONS, CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A); 28A. AUTOPSY? YES  NO  28B. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING THE CAUSE OF DEATH? 1  YES 2  NO 29. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 1  YES 2  NO

30A. SPECIFY IF ACCIDENT, HOMICIDE, SUICIDE, UNDETERMINED, PENDING INVESTIGATION 30B. DATE OF INJURY MONTH DAY YEAR 30C. HOUR OF INJURY M 30D. DESCRIBE HOW INJURY OCCURRED

30E. INJURY AT WORK? YES  NO  30F. PLACE OF INJURY HOME, FACTORY, OFFICE BLDG., ETC. 30G. LOCATION (STREET & NO., CITY OR VILLAGE, TOWN, COUNTY, STATE)

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C  
9  
3  
14  
USUAL RESIDENCE WHERE DECEDENT LIVED.  
16A  
16B  
SI  
25  
27  
30  
30G  
NCHS  
QR  
QS  
QCOD

NEW GARDENS OFFICE: (718) 225-3088  
BAYSIDE, N.Y. 11361  
204-05 35TH AVENUE  
P.O. BOX 419  
200-02, 46 Ave  
BAYSIDE, N.Y. 11361  
GARY H. TROP