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INSTRUCTIONS
FOR
MEDICAL CERTIFICATEIn giving
CAUSE OF DEATHdo not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
mode of dying,
such as heart failure,
hemiplegia, etc. It means
the disease, or compli-
cations which caused
death.Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.Conditions contrib-
uting to death but not
related to the terminal
disease condition given
(a).Note:- Chapter 137,
Acts of 1954, requires
Physicians to print or
write the cause or
causes of death on
death certificates, and
Chapter 48, Acts of
1949, requires Physi-
cians to print or type
name under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 1

PLACE OF DEATH

SUSSEX
(County)WINTHROP
(City or Town)No. WINTHROP COMMUNITY HOSPITAL (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME FRIEDA (TEICHMEIER) KRAMER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 164 SOMERSET AVE WINTHROP, St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....5.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 2 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN 2 1961 to JAN 2 1961I last saw her live on JAN 2 1961, death is said to
have occurred on the date stated above, at 255 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) LOBAR PNEUMONIA - LEFT 5 DAYS

Due To (b) CEREBRAL VASCULAR ACCT 3 DAYS

Due To (c) ARTERIO-SCLEROTIC & HYPER
TENSIVE HEART DIS EONG. 8 YRS.OTHER SIGNIFICANT CONDITIONS FAILURE
CARCINOMA OF UTERUS 2 YRS.

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL & XRAY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Myron N. King, M. D.

MYRON N. KING (PRINT OR TYPE SIGNATURE)

(Address) 222 PLEASANT ST. WINTHROP Date 1/2 1961

6 BELLEVUE CEMETERY LAWRENCE
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN. 5, 1961

7 NAME OF FUNERAL DIRECTOR J. B. EMMERT & SONS

ADDRESS 93 E. HAVERHILL ST. LAWRENCE

Received and filed JAN 3 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of LOUIS KRAMER
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 4 Months 4 Days If under 24 hours
Hours.....Minutes13 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) GERMANY
(State or country)

17 NAME OF FATHER HERMAN TEICHMEIER

18 BIRTHPLACE OF FATHER (City) GERMANY
(State or country)

19 MAIDEN NAME OF MOTHER MARIE HASE

20 BIRTHPLACE OF MOTHER (City) GERMANY
(State or country)21 Informant ALTRED W. TEICHMEIER
(Address) 1 OAK KNOLL RD. METHUENI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer Jan. 2, 1961

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Middlesex

(County)
Everett

(City or Town)

Whidden Memorial Hospital

No. _____ St. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Berenice A (Nickerson) Goodwin
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 15 Willow Ave. Winthrop, Mass.
(Usual place of abode)

Length of stay: In place of death.....years.....1.....months.....7.....days. In place of residence.....years.....13.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 5, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from Sept. 30 to January 5, 19_____, 19_____, to Jan. 5, 19_____,
I last saw her alive on Jan. 5, 19_____, death is said to have occurred on the date stated above, at 8:55 p.m.DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Carcinoma of PancreasDue To Secondary Carcinoma
(b) of LiverDue To Acute Dilation Heart
(c)OTHER
SIGNIFICANT
CONDITIONS

No

Was autopsy performed? Clinical Findings
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) John F. Williams
Everett 1-6, M. D.
(Address) _____ Date _____ 19616 Woodlawn Crematory Everett
Place of Burial or Cremation January 9, (City or Town)

DATE OF BURIAL _____ 19____

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
Winthrop, Mass.ADDRESS _____
Received and filed FEB 13 1961 _____ 19____

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Everett

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. _____ 2

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widow10a If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)
Benjamin F. Goodwin
(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 3 Months 18 Days If under 24 hours
Hours Minutes13 Usual Occupation: Teacher (retired)
(Kind of work done during most of working life)

14 Industry or Business: Public School

15 Social Security No. None

16 BIRTHPLACE (City) Wood Harbor
(State or country) Nova Scotia

17 NAME OF FATHER James Nickerson

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Adelia Garron

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant Etta G. English
(Address) Winthrop

A TRUE COPY

ATTEST: _____
(Registrar of City or Town where death occurred)

DATE FILED January 10, _____ 19____

RECEIVED



FEB 13 1961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

3

FORM R-301A

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Mount's Convalescent Home

STANDARD CERTIFICATE OF DEATH

Registered No.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Mary A. Murray

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 25 White St.
(Usual place of abode)

St. East Boston
(If nonresident, give city or town and State)

Length of stay: In place of death. years 3 months days. In place of residence. years months days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving
USE OF DEATH

do not enter
more than one
cause for each
f (a), (b) and (c)

This does not mean
mode of dying,
h as heart failure,
henia, etc. It means
disease, or compli-
cations which caused
th.

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

Conditions contrib-
ing to death but not
uted to the terminal
ase condition given
(a).

ote:- Chapter 137,
s of 1954, requires
sicians to print or
e the cause or
ses of death on
th certificates, and
pter 48, Acts of
9, requires Physi-
ns to print or type
ne under signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 6, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jane, 1959 to Jan 6, 1961
I last saw h alive on Jan 6, 1961, death is said to
have occurred on the date stated above, at 9:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular
Hemorrhage

Due To (b) arteriosclerosis
generalized

Due To (c) senility

INTERVAL BETWEEN ONSET AND DEATH

1 day

yo

yo

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Joseph Gregorie, M. D.
194 Washington Ave. Signature 1/7 61
(Address) Date 19

6 Holy Cross Malden
Place of Burial or Cremation Jan. 9 (City or Town) 61
DATE OF BURIAL 19

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS East Boston

Received and filed JAN 10 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED, WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
James F. Murray
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 94 AGE Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No.

16 BIRTHPLACE (City) Nova Scotia
(State or country)

17 NAME OF FATHER Andrew Cameron

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Elizabeth Morrison

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 James K. Murray
Informant (Address) 280 Revere St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but, also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

No. 46

Washington Ave

STANDARD
CERTIFICATE OF DEATH

Registered No. 4

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Selena Waterman (Bennett)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 46 Washington Ave.

St.

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death... years 1 months 14 days. In place of residence... years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

Jan.

7

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from

Mar. 1950, to Jan. 7, 1961

I last saw her alive on Jan. 7, 1961, death is said to
have occurred on the date stated above, at 10:45 P.M.INTERVAL
BETWEEN
ONSET AND
DEATH

weeks

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of
(weeks)

Due To

(b)

Carcinoma of
Bladder

1 yr

Due To

(c)

OTHER

SIGNIFICANT
CONDITIONSArteriosclerosis
general

9 mo

Was autopsy performed? no

What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Joseph P. Grogan

M. D.

(PRINT OR TYPE SIGNATURE)

(Address) Joseph P. Grogan

Date 1-7

1960

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Jan. 10,

1960

7 NAME OF

FUNERAL DIRECTOR

Ernest P. Caggiano

ADDRESS

147 Winthrop St. Winthrop

Received and filed

JAN 10 1961

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Edgar D. Waterman

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

87

AGE Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

Housewife

(Kind of work done during most of working life)

14 Industry

or Business:

at home

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Cape Breton
Canada17 NAME OF
FATHER

Henry Bennett

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Cape Breton
Canada

19 MAIDEN NAME

OF MOTHER

?

Young

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Cape Breton
Canada

21

Informant

(Address)

Mrs Doris Gillis

330 Selby St., Montreal, Que.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

11 V

PLACE OF DEATH

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 5

PLACE OF DEATH

SUSSEX

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FANNIE (BRENNER) COHEN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 200 WOODSIDE AVENUE St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months. 23 days. In place of residence. 22 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 8 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 57 to JAN 8 1961

I last saw her alive on 1/8 1961, death is said to have occurred on the date stated above, at 3:52 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral vascular accident

INTERVAL
BETWEEN
ONSET AND
DEATH
3 wks.

(b) Due To Hypertensive & atherosclerotic heart dis & congestive failure 3 wks.

(c) Due To General atherosclerosis 5 yrs.
AURICULAR FIBRILLATION - MYOCARDIALOTHER SIGNIFICANT CONDITIONS POST LEFT thigh amputation 4 yrs.
DIABETES MELLITUS MILD 1 yr.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Myron N. King M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 112 Pleasant St. Date 1/8 1961

6 ANSHA SEARD WINTHROP DANVERS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 9 1961

7 NAME OF FUNERAL DIRECTOR Louis Hyman
ADDRESS 112 Pleasant St. Wintthrop

Received and filed JAN 10 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED WIDOWED

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of JOSEPH B. COHEN (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years 2 Months 16 Days If under 24 hours Hours Minutes

13 Usual Occupation: HOUSEWIFE (Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) RUSSIA (State or country)

17 NAME OF FATHER KIVA BRENNER

18 BIRTHPLACE OF FATHER (City) RUSSIA (State or country)

19 MAIDEN NAME OF MOTHER EVA COHEN

20 BIRTHPLACE OF MOTHER (City) RUSSIA (State or country)

21 Informant WILLIAM COHEN 514
(Address) 37 PARKVIEW BLVD. GRANVILLE, OH

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

K. O. Jan 9, 1961
(Official Designation) (Date of Issue of Permit)

FORM R-301A

INSTRUCTIONS
FOR
MEDICAL CERTIFICATEIn giving
USE OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)his does not mean
mode of dying,
as heart failure,
mia, etc. It means
disease, or compli-
s which caused
h.Conditions, if any,
which gave rise to
one cause (a),
giving the under-
lying cause last.Conditions contrib-
ing to death but not
ed to the terminal
condition given
e).te: Chapter 137,
of 1954, requires
icians to print or
the cause or
es of death on
certificates, and
ter 48, Acts of
requires Physi-
s to print or type
under signature.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

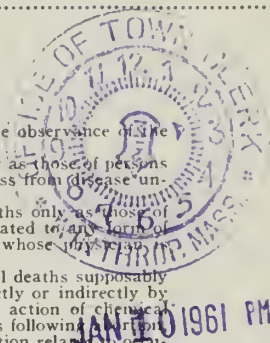
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physicians were absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following a rupture but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 6

PLACE OF DEATH

Suffolk
Winthrop.
(City or Town)

No. Mayflower Rest Home.

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

2 FULL NAME

Frank Colabelli
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No.

(a) Residence. No.

224 Hanover

St.

Boston Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHJan. 8 1961.
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov 5 1959 to JAN 8 1961.I last saw him alive on JAN 8 1961, death is said to
have occurred on the date stated above, at 9:30 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

INTERVAL
BETWEEN
ONSET AND
DEATH
5 DAYSDue To (b) GENERALIZED ARTERIO-
SCLEROSIS

10 YRS

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

DIABETES

3 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Joseph J. Halermo, M. D.

JOSEPH J. HALERMO
(PRINT OR TYPE SIGNATURE)

(Address) Revere, Mass. Date JAN 10 1961

6 Place of Burial or Cremation St. Michael Cemetery

DATE OF BURIAL Jan. 11 1961

7 NAME OF

FUNERAL DIRECTOR Joseph A. Langone

ADDRESS 55 W. Main St. Boston

Received and filed JAN 10 1961

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Angelina Di Rienzo
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 70 Years 7 Months 7 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Retired
(Kind of work done during most of working life)

14 Industry

or Business: Self Employed.

15 Social Security No.

None

16 BIRTHPLACE (City)

(State or country) Italy

17 NAME OF

FATHER Giovanni Colabelli

18 BIRTHPLACE OF

FATHER (City) Italy

(State or country)

19 MAIDEN NAME

OF MOTHER Unkenocon

20 BIRTHPLACE OF

MOTHER (City) Italy

(State or country)

21

Informant (Address) Beta Intero

Winthrop St. Mel

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

H.O. [Signature] Jan 10/61

(Official Designation)

(Date of Issue of Permit)

(Registrar)

RM R-301A

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATEIn giving
PLACE OF DEATHdo not enter
more than one
place for each
(a), (b) and (c)does not mean
mode of dying,
is heart failure,
a, etc. It means
cause, or compli-
which causedConditions, if any,
which gave rise to
the cause (a),
giving the under-
lying cause last.Conditions contrib-
uting to death but not
to the terminal
condition givenChapter 137,
of 1954, requires
physicians to print or
type the cause or
causes of death on
certificates, and
Chapter 48, Acts of
1954, requires Physi-
cians to print or type
their names under signature.

1-6-59-925686

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease related to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No.

No. On sidewalk at 143 Revere Street St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James L. Butler { (If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Residence. No. 143 Revere Street, Winthrop St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death. 2 years months days. In place of residence 2 years months days.

INSTRUCTIONS
FOR
CERTIFICATE

OF DEATH

not enter
re than one
se for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
etc. It means
ase, or compli-
which caused

tions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
r 48, Acts of
quires Physi-
o print or type
nder signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 11 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 5-11-60, 1960, to 1-11-61, 1961
I last saw him live on 1-11-61, 1961, death is said to have occurred on the date stated above, at 8:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) CORONARY OCCLUSION

Due To CORONARY SCLEROSIS

OTHER SIGNIFICANT CONDITIONS

INTERVAL
BETWEEN
ONSET AND
DEATH
SUB
DENT

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) Married
MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Theresa M. Ruggiero
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 50 Years 9 Months 29 Days If under 24 hours _____
Hours _____ Minutes _____

13 Usual Occupation: Yard man
(Kind of work done during most of working life)

14 Industry or Business: Oil Co.

15 Social Security No. 028-03-2420

16 BIRTHPLACE (City) Everett (State or country) Mass.

PARENTS

17 NAME OF FATHER Richard Butler

18 BIRTHPLACE OF FATHER (City) _____ (State or country) P.E.I.

19 MAIDEN NAME OF MOTHER Annie Johnston

20 BIRTHPLACE OF MOTHER (City) _____ (State or country) P.E.I.

Was autopsy performed? 0

What test confirmed diagnosis? _____

5 Was disease or injury in any way related to occupation of deceased? 0
If so, specify _____

(Signed) Frederic O'Regan, M. D.
FRED O'REGAN, M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 113 PLEASANT WINTHROP
Date 1-11-61

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 14th 1961

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St., E. Boston

Received and filed JAN 16 1961 19 _____

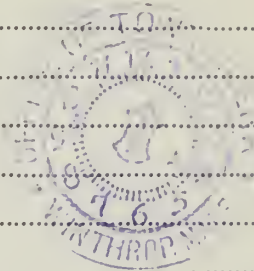
21 Informant (Address) Mrs. Theresa M. Butler-wife
143 Revere St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) John E. [Signature]
HO (Official Designation) 1/12/61 (Date of Issue of Permit)

Medical Examination Report as of 1/19/61

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



JAN 12 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.Suffolk
(County)Winthrop
(City or Town)

Winthrop Convalescent Home

No. 142 Pleasant St.

STANDARD
CERTIFICATE OF DEATH

Registered No. 8

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)2 FULL NAME Florence Mackinnon
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 556 Shirley Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 4 months days In place of residence 50 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 11 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
May 1960 to Jan 11 1961I last saw him alive on Jan 10 1961, death is said to
have occurred on the date stated above, at 7:10 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

Due To (b) arteriosclerosis -

Due To (c) generalized senility

OTHER SIGNIFICANT CONDITIONS Fracture of Humerus - rk

INTERVAL
BETWEEN
ONSET AND
DEATH
yr

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Joseph D. Ward, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 194 Washington St. Date 1/11 1961

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 13 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed JAN 16 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Single10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Dressmaker
(Kind of work done during most of working life)

14 Industry or Business: Clothing

15 Social Security No. 028-16-6743

16 BIRTHPLACE (City) Cape Breton
(State or country) Nova Scotia

17 NAME OF FATHER Dougal MacKinnon

18 BIRTHPLACE OF FATHER (City) Cape Breton
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Margaret MacEachern

20 BIRTHPLACE OF MOTHER (City) Cape Breton
(State or country) Nova Scotia21 Informant Isabelle MacKinnon
(Address) 556 Shirley St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

H. O. [Signature] 1/13/61

(Official Designation)

(Date of Issue of Permit)

INSTRUCTIONS
FOR
CERTIFICATEIn giving
OF DEATHnot enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
i, etc. It means
ease, or compli-
which causeditions, if any,
t gave rise to
cause (a),
g the under-
cause last.nditions contrib-
o death but not
to the terminal
condition givencal Examiner
ed Juris-
ione:- Chapter 137,
of 1954, requires
icians to print or
the cause or
s of death on
certificates, and
ter 48, Acts of
requires Physi-
to print or type
under signature.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 9

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Emilie Martine Nelson (Enholm)

PHYSICIAN — IMPORTANT

2 FULL NAME ~~Emilie Martine Nelson~~
Emma Enholm Nelson

(If deceased a
U. S. War Veteran,
if so specify WAR)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 41 Temple Ave
(Usual place of abode)

Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1.....days. In place of residence.....45.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 11 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 30, 1955 Jan. 11 1961

I last saw alive on 1-11-1961 death is said to
have occurred on the date stated above, at 10.45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart
disease

Due To Generalized arterioscler-
(b) osis

Due To None
(c)

OTHER SIGNIFICANT
CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical and Lab.

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signed) M. Traunstein, Jr. M. D.
M. Traunstein, Jr. M. D.
(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Winthrop, Mass.

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 14, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JAN 13 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word)
MARRIED widowed
WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Victor Emanuel Nelson
(Husband's name in full)

11 IF STILLBORN, enter that fact here.
12 AGE 36 Years 11 Months 28 Days
If under 24 hours
Hours.....Minutes

13 Usual Occupation: house work
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) Moss Norway
(State or country)

17 NAME OF FATHER Johan Enholm

18 BIRTHPLACE OF FATHER (City) Norway
(State or country)

19 MAIDEN NAME OF MOTHER Karen Matheson
unable to obtain

20 BIRTHPLACE OF MOTHER (City) Norway
(State or country)

21 Informant Nils Victor Nelson
(Address) 8 Temple Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sirianian
(Signature of Agent of Board of Health or other)

HO (Official Designation) 1/13/61 (Date of Issue of Permit)

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

In giving
STATE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
mia, etc. It means
disease, or compli-
is which caused

ditions, if any,
ich gave rise to
ne cause (a),
ting the under-
ng cause last.

Conditions contrib-
to death but not
d to the terminal
e condition given

Chapter 137,
of 1954, requires
physicians to print or
the cause or
s of death on
certificates, and
ter 48, Acts of
requires Physi-
to print or type
under signature.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Winchester

(City or town making return)

Registered No. 10

PLACE OF DEATH

Middlesex

(County)

Winchester

(City or Town)

Winchester Hospital

No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Dorothy M. Howe (Marshall)

2 PULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

42 Floyd Street

Winthrop, Mass.

(Was deceased a U. S. War Veteran,
if so, specify WAR) no

(a) Residence. No.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

January

14

1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)
CARDIAC ARREST WHILE UNDER THE INFLUENCE
OF SURITAL * ETHER ANESTHESIA USED AS
ANESTHETIC FOR CLOSURE OF PERFORATED
CECUM CAUSED BY CANCER.

5 Accident, suicide, or homicide (specify)

Date and hour of injury

19

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public
place?

(Specify type of place)

Manner of
InjuryNature of
Injury

While at work? Was autopsy performed?

yes

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Harry L. Benson

(Address) 109 Main St., Winchester 1-14-61 M.D.

Salem Hill Cemetery No. Dickinson 19

7 Place of Burial, or Cremation. 1-16-61 (City or Town)

DATE OF BURIAL

8 NAME OF
FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 14 Winthrop St., Winthrop, Mass.

Received and filed. FEB 13 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

Female

10 COLOR OR RACE

White

11 SINGLE

MARRIED

WIDOWED

or DIVORCED

(write the word)

Married

11a If married, widowed, or divorced

HUSBAND of

Albert Marshall (full)

(or) WIFE of

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE Years Months Days If under 74 hours

housework

14 Usual

Occupation:

(Kind of work done during most of working life)

15 Industry

or Business:

own home

16 Social Security No.

Edgerstown

17 BIRTHPLACE (City)

Mass.

(State or country)

18 NAME OF

FATHER

Francis Joseph Marshall

19 BIRTHPLACE OF

FATHER (City)

Mass.

(State or country)

20 MAIDEN NAME Charlotte Bearse

OF MOTHER

21 BIRTHPLACE OF

MOTHER (City)

Hyannis

(State or country)

22

Informant

(Address)

Albert Walter Howe
12 Floyd St., Winthrop, Mass.

A TRUE COPY.

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

1-17-61

19--

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-303 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

RECEIVED



FEB 13 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. **11**

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)No. **76 Summit Avenue** St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Nancy Mary Schille**
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. **76 Summit Avenue** St.
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death.....years **8** months **20** days. In place of residence.....years **8** months **20** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **January 16, 1961**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 27, 60 to **January 16, 61**
I last saw him alive on **January 16, 1961**, death is said to
have occurred on the date stated above, at **10:15 a. m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Myelomeningocele with
hydrocephalus**INTERVAL
BETWEEN
ONSET AND
DEATH
8 mos.Due To
(b)Due To
(c)OTHER SIGNIFICANT
CONDITIONS **Abdominal ascites****3 wks.**Was autopsy performed? **no**
What test confirmed diagnosis? **Clinical & Laboratory**5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify(Signed) **M. Traunstein, Jr., M. D.**
(PRINT OR TYPE SIGNATURE)(Address) **73 Bartlett Rd., Jan. 16, 1961**
Winthrop 52, Mass. WAKEFIELD6 **Forest Glass**
Place of Burial or Cremation (City or Town)
DATE OF BURIAL **Jan. 18, 1961**7 NAME OF FUNERAL DIRECTOR **William H. Butler**
ADDRESS **52 Albion St., Wakefield, Mass.**Received and filed **JAN 13 1961** 19.....

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **FEMALE** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED **Single**
WIDOWED **Single**
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **8** Years **8** Months **20** Days If under 24 hours
Hours..... Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry
or Business:

15 Social Security No.

16 BIRTHPLACE (City)
(State or country) **Winthrop
Mass**17 NAME OF FATHER **William S. Schille**18 BIRTHPLACE OF FATHER (City)
(State or country) **Stratford
Conn**19 MAIDEN NAME OF MOTHER **Roberta E. Riley**20 BIRTHPLACE OF MOTHER (City)
(State or country) **Boston
Mass**21 Informant **Mrs Roberta E Schille**
(Address) **76 Summit Ave, Winthrop**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:**Ralph E. Williams**
(Signature of Agent of Board of Health or other)

H.D. (Official Designation)

1/16/61 (Date of Issue of Permit)

RM R-301A

INSTRUCTIONS
FOR
LOCAL CERTIFICATEIn giving
USE OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)s does not mean
mode of dying,
as heart failure,
etc. It means
cause, or compli-
cations which causedditions, if any,
which gave rise to
the cause (a),
including the under-
lying cause lost.conditions contrib-
uting to death but not
leading to the terminal
condition givenChapter 137,
of 1954, requires
physicians to print or
type the cause or
causes of death on
certificates, and
under 48, Acts of
1954, requires Physi-
cians to print or type
under signature.

M-11-59-926662

(Registrar)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on back side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



ORM R-304

PLACE OF DELIVERY

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital, Winthrop

2 NAME OF FETUS ... Premature Female Sera
(if given)3 DATE OF DELIVERY Jan. 17, 1961
(Month) (Day) (Year)

Registered No. 12

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)4 SEX
Male ... Female ☒ Undetermined ...

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin Triplet.7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd ...

8 FULL NAME

Alfred D. Sera

FATHER

14

MAIDEN NAME Kathleen T. Griffin

MOTHER

PRESENT NAME Kathleen T. Sera

9 RESIDENCE, NO. 105 Garfield Avenue STREET
CITY OR TOWN Chelsea STATE Mass.15 RESIDENCE, NO. 105 Garfield Avenue STREET
CITY OR TOWN Chelsea STATE Mass.

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 37

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 35 (Years)

12 PLACE OF BIRTH E. Boston, Massachusetts
(City or Town) (State or country)18 PLACE OF BIRTH Medford, Massachusetts
(City or Town) (State or country)

13 OCCUPATION Accountant

19 INFORMANT Mother

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

(a) How many children are now living? 6

(b) How many children were born alive but are now dead? 0

(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY 6 mos. completed weeks

22 WEIGHT OF FETUS 2 Lb. - Oz (or Grams)

23 WHEN DID FETUS DIE? Before ☒ Labor During Labor or Delivery. Unknown24 AUTOPSY Yes No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Placenta Previa

Due To (b) Premature Separation of Placenta

Due To (c)

OTHER SIGNIFICANT CONDITIONS

None

26 Woodlawn, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 18, 1961

27 NAME OF FUNERAL DIRECTOR John B. Welsh
ADDRESS 718 Broadway Chelsea

Received and filed

19

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF FETAL DEATH
(STILLBIRTH)To be filed for burial permit with
Board of Health or its Agent.In giving
CAUSE OF
FETAL DEATHdo not enter
more than one
cause for each
of (a), (b)
and (c)fetal or maternal
condition causing
fetal death (do
not use such
terms as stillbirth
or prematurity.)fetal and/or maternal
conditions,
any, which gave
rise to above
use (a), stating
the underlying
cause last. →→
conditions of fetus
mother which
may have contrib-
uted to fetal
death, but, in so
far as is known,
are not related
to cause given
(a).I HEREBY CERTIFY that this delivery occurred on the date stated
above at 12:30 A.M. and product of conception was not a live birth.

Signature _____, M.D.

A. Paul DerHagopian, M.D.

(PRINT OR TYPE SIGNATURE)

Address 39 Cary Ave., Chelsea at 1/17/ 1961

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Serianum
(Signature of Agent of Board of Health or other)HO 1/18/61
(Official Designation) (Date of Issue of Permit)

RECEIVED



FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

JAN 18 1961 AM

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No. 13

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Mary A. McGillicuddy

(First Name) (Middle Name) (Last Name)

{(Was deceased a U. S. War Veteran, No
if so specify WAR)}

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No. 39 Pico Avenue

St. (If nonresident, give city or town and State)

Length of stay: In place of death, 1 years, 1 months, 0 days. In place of residence, 50 years, 0 months, 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 19 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

Dec 18 60, 1960, to 1/19, 1961

I last saw alive on 1/19, 1961, death is said to have occurred on the date stated above, at 4:45 p.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHO-PNEUMONIA

Due To (b) CEREBRAL

Due To (c) THROMBOSIS

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? 0

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? 0

If so, specify

(Signed) Fred O. Regan, M.D.

PRINT OR TYPE SIGNATURE

(Address) 113 Pleasant St, Winthrop

6 Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 23 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JAN 24 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Married

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William H. McGillicuddy (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years, 0 Months, 0 Days If under 24 hours Hours, 0 Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Everett (State or country) Mass

17 NAME OF FATHER William Harron

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Mary J. Meakin

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Nancy McGillicuddy (Address) 39 Pico Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

(Official Designation) (Date of Issue of Permit)

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

1. Giving
OF DEATH

2. Do not enter
more than one
cause for each
(a) (b) and (c)

3. Does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
cations which caused

4. Conditions, if any,
which gave rise to
cause (a),
the under-
lying cause last.

5. Conditions contrib-
uting to death but not
the terminal
condition given

6. Chapter 137,
of 1954, requires
physicians to print or
type the cause or
mode of death on
certificates, and
under 48, Acts of
1954 requires Physi-
cians to print or type
under signature.

M.C.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk

(County)
Winthrop

(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. _____

No. 20 Lewis Avenue

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Bertha Rosen
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, no.
if so specify WAR)

(a) Residence. No. 25 Parkman St. Brookline, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 months 30 days. In place of residence 30 years 30 months 30 days.

INSTRUCTIONS
FOR
CERTIFICATE

In giving
OF DEATH

not enter
more than one
cause for each
(a), (b) and (c)

Does not mean
mode of dying,
is heart failure,
etc. It means
cause, or compli-
which caused

itions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
to death but not
to the terminal
condition given

Chapter 137,
of 1954, requires
ians to print or
the cause or
of death on
certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Apr. 21, 1961 to Jan. 18, 1961

I last saw her alive on Jan. 18, 1961, death is said to
have occurred on the date stated above, at 6 a. m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of the ovary 1 yr.
metastatic to abdomen

metastatic

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no.

What test confirmed diagnosis? Clinical & cytological

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify
Ernst Conn, M.D.

(Signed) Ernst Conn, M. D.

(Address) 39 Columbia Road, Dorchester
Date Jan. 21, 1961

6 Pride of Jacob, West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 22, 1961

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon
420 Harvard Street, Brookline
ADDRESS

Received and filed JAN 24 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED widowed

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
Joseph Rosen

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 68 AGE 68 Years 68 Months 68 Days If under 24 hours
68 Hours 68 Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry
or Business:

15 Social Security No.

16 BIRTHPLACE (City) Poland
(State or country)

17 NAME OF FATHER Morris Rosen (O.K.)

18 BIRTHPLACE OF FATHER (City) Poland
(State or country)

19 MAIDEN NAME OF MOTHER (unknown)

20 BIRTHPLACE OF MOTHER (City) Poland
(State or country)

21 Informant Estelle Cohen
(Address) 20 Lewis Avenue, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan
Signature of Agent of Board of Health or other
H.O. Jan. 21-1961

(Official Designation)

(Date of Issue of Permit)

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also insert in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteen, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the time of death is needed.
- (3) **Medical examiners** will investigate and certify to all deaths supposedly due to injury, including not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Essex
(County)

Danvers
(City or Town)

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. **13**

No. **Danvers State Hospital, Hathorne** St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME **Elizabeth Colbert (Smith)** { (Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence. No. **7 Willis** Avenue // **Winthrop, Mass.**
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death **4** years **8** months **10** days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH January 21, 1961 (Month) (Day) (Year)		8 SEX female	9 COLOR white
4 I HEREBY CERTIFY, That I attended deceased from May 11, 1956 to January 21, 1961		10 SINGLE (write the word) WIDOWED	
I last saw her live on January 21, 1961 death is said to have occurred on the date stated above, at 7:00a.m.		10a If married, widowed or divorced married (Give maiden name of wife in full) Benjamin Arnold	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE		(or) WIFE of 2. William Colbert (Husband's name in full)	
(a) Arteriosclerotic Heart Disease		11 IF STILLBORN, enter that fact here.	
(b) Generalized Arteriosclerosis		12 AGE 79 Years 7 Months 5 Days	If under 24 hoursHours.....Minutes
(c) years		13 Usual Occupation: Waitress & Cook-Retired (Kind of work done during most of working life)	
OTHER SIGNIFICANT CONDITIONS		14 Industry or Business: 024-01-0342A	
Was autopsy performed? yes		15 Social Security No. Lawrence,	
What test confirmed diagnosis? autopsy		16 BIRTHPLACE (City) Mass. (State or country)	
5 Was disease or injury in any way related to occupation of deceased? no		17 NAME OF FATHER George Smith	
If so, specify		18 BIRTHPLACE OF FATHER (City) Lawrence, (State or country) Mass.	
(Signed) Andrew Nichols III M. D.		19 MAIDEN NAME OF MOTHER Mary Hopping	
(Address) Hathorne, Mass. Date 1/21/1961		20 BIRTHPLACE OF MOTHER (City) Lawrence, (State or country) Mass.	
6 Woodlawn Cemetery, Everett, Mass. Place of Burial or Cremation (City or Town)		21 Informant Mary E. Sheehan (Address) Hathorne, Mass.	
DATE OF BURIAL January 24, 1961		A TRUE COPY Daniel J. Toomey	
7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano		ATTEST: (Registrar of City or Town where death occurred)	
ADDRESS Winthrop, Mass.		DATE FILED January 25, 1961	
Received and filed JAN 30 1961			
(Registrar of City or Town where deceased resided)			



JAN 30 1961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

M R-301A

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 38 Forrest St.

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 16

To be filed for burial permit
with Board of Health
or its Agent.{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Estelle Bornstein

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) NoINSTRUCTIONS
FOR
CERTIFICATE(a) Residence, No. 38 Forrest St.
(Usual place of abode)St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 38 years... months... days. In place of residence 38 years... months... days.

giving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
do the terminal
condition given

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 23 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Cot. 470 to JAN 23 1961I last saw her alive on Jan 23 1961, death is said to
have occurred on the date stated above, at 4:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion, Acute 1 day

(b) Hypertensive Coronary 10 yrs

(c) Artery Heart Disease

OTHER SIGNIFICANT CONDITIONS Left Hemiparesis 11 yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Charles Liberman M. D.
Charles Liberman

(Address) 238 Street or Type Signature Winthrop Date 1/23 1961

6 Tifereth Israel of Winthrop Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 24 1961

7 NAME OF FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed JAN 24 1961 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Married
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Theodore Bornstein
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 62 Years... Months... Days If under 24 hours
Hours... Minutes13 Usual Occupation: House-wife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.

16 BIRTHPLACE (City) Canada
(State or country)

17 NAME OF FATHER Jacob Trattenberg

18 BIRTHPLACE OF FATHER (City) Lithuania
(State or country)

19 MAIDEN NAME OF MOTHER Pauline Geffen

20 BIRTHPLACE OF MOTHER (City) Lithuania
(State or country)21 Informant Theodore Bornstein
(Address) 38 Forrest St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Liberman
(Signature of Agent of Board of Health or other)H.O. At Jan 23 1961
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
FILLING OUT THIS CERTIFICATE

giving
OF DEATH

not enter
more than one
cause for each
(a) (b) and (c)

does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which caused

causes, if any,
to give rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Chapter 137,
of 1954, requires
physicians to print or
the cause or
of death on
certificates, and
Chapter 48, Acts of
1919, requires Physi-
cians to print or type
under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 17

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 42 Atlantic Street

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME George J. Clarson

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
{ if so specify WAR)

(a) Residence, No. 42 Atlantic St.,
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. days. In place of residence 22 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 24, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan. 1, 1960 to Jan. 24, 1961

I last saw him alive on Jan. 24, 1961, death is said to
have occurred on the date stated above, at 1 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia
Due To (b) Arteriosclerosis 1946

Due To (c) Chronic Nephritis 1946

OTHER SIGNIFICANT CONDITIONS Cerebral Hemorrhage 1-15-61
Colostomy 1946

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) A. N. Caplan, M. D.
A. N. CAPLAN, MD
(PRINT OR TYPE SIGNATURE)

(Address) 86 PRINCETON ST. Date 1-24-61
EAST BOSTON

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 28, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JAN 26 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED or WIDOWED or DIVORCED

10a If married, widowed or divorced
HUSBAND of Harriet M. McDermott
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years. Months. Days If under 24 hours
Hours. Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: Electrical Contractor

15 Social Security No. 023-14-6873

16 BIRTHPLACE (City) Brooklyn
(State or country) New York

17 NAME OF FATHER Michael Clarson

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary Ahern

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Harriet M. Clarson
(Address) 42 Atlantic St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

HO. 126/61

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. **60 Johnson Avenue**



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. **18**

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

((Was deceased a
U. S. War Veteran **CBL**
[if so specify WAR])

2 FULL NAME **Clarence A. Martin**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. **60 Johnson Avenue, Winthrop** St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. **24** years. months. days In place of residence **24** years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **January 24, 1961**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
October 25, 1960 to **January 24, 1961**

I last saw him alive on **January 24, 1961**, death is said to
have occurred on the date stated above, at **10:20 p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Acute myocardial infarction**

INTERVAL
BETWEEN
ONSET AND
DEATH

3 mos

Due To (b) **Arteriosclerotic and hyper-
tensive heart disease** **10**
years

Due To (c) **Generalized arteriosclerosis** **12**
years

OTHER
SIGNIFICANT
CONDITIONS **none**

Was autopsy performed? **no**
What test confirmed diagnosis? **Clinical and Lab.**

5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify

(Signed) **M. Traunstein, Jr.**, M. D.
M. Traunstein, Jr., M. D.
(PRINT OR TYPE SIGNATURE)

(Address) **73 Bartlett Rd. Win.** Date **Jan. 25, 1961**

6 **Winthrop Cemetery, Winthrop**
Place of Burial or Cremation (City or Town)
DATE OF BURIAL **January 27th** 19 **61**

7 NAME OF FUNERAL DIRECTOR **Richard C. Kirby, Inc.**
917 Bennington St., E. Boston
ADDRESS

Received and filed **JAN 26 1961** 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED **Widowed**

10a If married, widowed, or divorced
HUSBAND of **Alice Dixon**
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **80** Years **8** Months **20** Days
If under 24 hours
Hours Minutes

13 Usual Occupation **Boston Harbor Pilot-Retired**
(Kind of work done during most of working life)

14 Industry or Business **Pilot Boats**

15 Social Security No. **CBL**

16 BIRTHPLACE (City) **East Boston**
(State or country) **Mass.**

17 NAME OF FATHER **Ambrose A. Martin**

18 BIRTHPLACE OF FATHER (City) **Boston**
(State or country) **Mass.**

19 MAIDEN NAME OF MOTHER **Annie Beadle**

20 BIRTHPLACE OF MOTHER (City) **Boston**
(State or country) **Mass.**

21 Informant **Miss Georgia Morgan**
(Address) **60 Johnson Ave., Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

(Registrar)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

1 R-301A

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 19

No. 210 Main Street

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Jane Culkeen (Sheerin)

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 210 Main St., St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence. life.....years.....months.....days.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
se, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.itions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
ians to print or
the cause or
of death on
certificates, and
r 48, Acts of
quires Physi-
o print or type
nder signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 25, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
OCT 19 1960, to JAN 25 1961I last saw h. alive on 1/25/61, 1961, death is said to
have occurred on the date stated above, at 10:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE PULMONARY EDEMA

Due To MYOCARDIAL DISEASE

Due To ARTERIO-SCLEROTIC HEART

(c) DIS. WITH CONGESTIVE FAILURE

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Myron N. King, M.D.

(Address) 222 Pleasant St. Winthrop, Mass. Date 1/25/61

6 Holy Cross Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 27 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed JAN 26 1961 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Female White MARRIED

10a If married, widowed or divorced

HUSBAND of Fred Culkeen

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years.....Months.....Days

If under 24 hours Hours.....Minutes

13 Usual Occupation: Retired

(Kind of work done during most of working life)

14 Industry or Business: Sales lady Raymonds

15 Social Security No. 011-24-6846

16 BIRTHPLACE (City) Winthrop

(State or country) Mass

17 NAME OF FATHER Patrick Sheerin

18 BIRTHPLACE OF FATHER (City) Ireland

FATHER (State or country)

19 MAIDEN NAME OF MOTHER Susan Sheekey

20 BIRTHPLACE OF MOTHER (City) Ireland

MOTHER (State or country)

21 Informant Fred Culkeen

(Address) 28 Schofield Dr., Newton

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 20

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 15 Siren Street

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Mary (Haggerston) Lougee
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 15 Siren Street
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 50 years months days. In place of residence 91 years 0 months 28 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 25, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
January 7, 1952 to January 25, 1961
I last saw him alive on January 25, 1961, death is said to
have occurred on the date stated above, at 9:20 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic and hypertensive
heart disease

8 yrs

Due To Generalized arteriosclerosis

(b)

10 yrs

Due To

OTHER SIGNIFICANT CONDITIONS Hypertrophic arthritis

12 yrs

Was autopsy performed? no

What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein, Jr., M.D.

(PRINT OR TYPE SIGNATURE)
M. Traunstein, Jr., M.D.

(Address) 73 Bartlett Rd. Date January 26, 61

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 28 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass

Received and filed JAN 30 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCE Widow10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
Edwin Lougee
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 0 Months 28 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Winthrop
(State or country) Mass

17 NAME OF FATHER Alexander Haggerston

18 BIRTHPLACE OF FATHER (City) Watertown
(State or country) Mass

19 MAIDEN NAME OF MOTHER Louisa Tewksbury

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Mass21 Informant Eva Murray
(Address) 90 Terrace Ave. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:D. E. Schuman
(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 1/27/61

M R-301A

INSTRUCTIONS
FOR
AL CERTIFICATEn giving
E OF DEATHnot enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
, etc. It means
ase, or compli-
which causedtions, if any,
n gave rise to
cause (a),
g the under-
cause last.ditions contrib-
n death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
b print or type
nder signature.

11-59-926662

SPACE FOR ADDITIONAL INFORMATION
 DATE OF ENTERING MILITARY SERVICE
 DATE OF DISCHARGE
 RANK, RATING
 ORGANIZATION AND OUTFIT
 SERVICE NUMBER

JAN 30 1961 PM
 RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

Registered No. 21

1 PLACE OF DELIVERY
Suffolk County
Winthrop (City or Town)
No. Winthrop Community Hospital

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 NAME OF FETUS Baby Boy Foti
(if given)

3 DATE OF DELIVERY 1 26 61
(Month) (Day) (Year)

4 SEX Male Female Undetermined

5 COLOR (if determined) A

6 THIS BIRTH (Check one)
Single Twin Triplet

7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd

FATHER

8 FULL NAME Ralph Foti

9 RESIDENCE, NO. 164 Cottage STREET
CITY OR TOWN East Boston STATE Mass

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 38 (Years)

12 PLACE OF BIRTH Boston Mass
(City or Town) (State or country)

13 OCCUPATION Pressman

MOTHER

14 MAIDEN NAME Antonetta Camiolo
PRESENT NAME Antonetta Foti

15 RESIDENCE, NO. 164 Cottage STREET
CITY OR TOWN East Boston STATE Mass

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 38 (Years)

18 PLACE OF BIRTH Boston Mass
(City or Town) (State or country)

19 INFORMANT Mother

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

(a) How many children are now living? 3

(b) How many children were born alive but are now dead? 0

(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY 26 completed weeks

22 WEIGHT OF FETUS 2 Lb. 4 Oz
(or Grams)

23 WHEN DID FETUS DIE?
Before Labor X During Labor or Delivery Unknown

24 AUTOPSY Yes No X

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Premature scarring of placenta

Due To (b) Premature separation and bleeding causing insufficient blood supply to fetus

OTHER SIGNIFICANT CONDITIONS

26 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JAN. 27, 1961

27 NAME OF FUNERAL DIRECTOR DI PIETRO VAZZA
ADDRESS 11 HENRY ST, EAST BOSTON

Received and filed

JAN 26 1961

Registrar

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 9:55 AM and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

A. N. Caplan M.D.

A. N. Caplan (PRINT OR TYPE SIGNATURE)

Address East Boston Date 1/26/61

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianum
(Signature of Agent of Board of Health or other)

H.O. (Official Designation)

1/26/61 (Date of Issue of Permit)

In giving
CAUSE OF
FETAL DEATH

do not enter
more than one
cause for each
of (a), (b)
and (c)

al or maternal
dition causing
al death (do
t use such
ms as stillbirth
prematurity.)

al and/or mal-
nal conditions,
ny, which gave
se to above
se (a), stating
e underlying
se last.

ditions of fetus
mother which
y have contrib-
ed to fetal
th, but, in so
as is known,
re not related
cause given
(a).

RECEIVED



EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of abnormal birth returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-6-60-928115

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 22

No. Winthrop Police Hdqtrs.

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME HAROLD E. FRENCH

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

((Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 183 Winthrop St.
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 69 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 28, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)

Coronary occlusion;
Acute myocardial infarction.

5 Accident, suicide, or homicide (specify)

Date and hour of injury19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
Injury occur?

Did injury occur in or about home, on farm, in industrial place, or in
public place?

Manner of
Injury

Nature of
Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

(Print or Type Signature)

(Address) Boston, Mass. Date Jan. 29, 1961

7 Winthrop, Cemetery, Winthrop
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Feb. 2, 1961

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St. Winthrop, Mass.

Received and filed JAN 30 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)
MARRIED WIDOWED ~~SINGLE~~ MARRIED
or DIVORCED

11a If married, widowed or divorced
HUSBAND of Anna V. Dempsey
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 69 Years - Months - Days If under 24 hours
A. Hours Minutes

14 Usual Occupation: Costable
(Kind of work done during most of working life)

15 Industry or Business: Town of Winthrop

16 Social Security No. 001-09-7473

17 BIRTHPLACE (City) Winthrop
(State or country) Mass.

18 NAME OF FATHER Ora French

19 BIRTHPLACE OF FATHER (City) not known
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Mary J. Sawyer

21 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

22 Informant Mrs. Anna French
(Address) 183 Winthrop St. Winthrop Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Neumann
(Signature of Agent of Board of Health or other)
H O (Official Designation) Jan 30/61 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 23

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Mary C (Hurley) Sullivan

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 50 Bates Avenue
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death. years. months. 4 days. In place of residence. 60 years. months. days.

INSTRUCTIONS
FOR
CERTIFICATEIn giving
OF DEATHdo not enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
i, etc. It means
ease, or compli-
which causedditions, if any,
gave rise to
cause (a),
g the under-
cause last.ditions contrib-
to death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
ificates, and
48, Acts of
quires Physi-
o print or type
nder signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 1 29 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Dec 1, 1960, to 1/29, 1961
I last saw h. alive on 1/29, 1961, death is said to
have occurred on the date stated above, at 6.30P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHOPNEUMONIA

INTERVAL
BETWEEN
ONSET AND
DEATH

3 DAYS

Due To ADTERIO-SCLEROTIC
(b) HEART DISEASEDue To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? 0

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? 0
If so, specify

(Signed) Fred O'Regan, M. D.

FRED O'REGAN, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 113 PLEASANT ST Date 1/29 1961

6 Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 1 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed 19

JAN 30 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)
Edward F. Sullivan

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 88 If under 24 hours
AGE. Years. Months. Days Hours. Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Dorchester
(State or country) Mass

17 NAME OF FATHER John Hurley

18 BIRTHPLACE OF FATHER (City) Frederickton
(State or country) New Brunswick

19 MAIDEN NAME OF MOTHER Mary McGrath

20 BIRTHPLACE OF MOTHER (City) Frederickton
(State or country) New Brunswick21 Helan A. Sullivan
Informant (Address) 50 Bates Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. McNamee
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 1/30/61

RECEIVED

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

JAN 30 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only, as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

R-301A

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 24

No. Winthrop Convelecent Home (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Hermine J. Crane (Mugler) (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 24 Spring St. Mansfield, Mass. St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 1 months 11 days. In place of residence 5 years 5 months 8 days.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHot enter
than one
for each
(b) and (c)es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedms, if any,
ave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
the terminal
condition givenChapter 137,
95A, requires
as to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 30 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
November 23, 1960, to January 30, 1961.I last saw him alive on January 29, 1961, death is said to
have occurred on the date stated above, at 3:00 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

INTERVAL
BETWEEN
ONSET AND
DEATH
7 DAYS

Due To (b) HYPERTENSION

10 yrs

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Dorothy Cheney Appleton M. D.
DOROTHY CHENEY APPLETON M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 197 Woodland Ave. Date Jan 30 1961

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 1, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed
WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Charles A. Crane
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 4 Months 2 Days If under 24 hours
Hours Minutes13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) Meriden
(State or country) Connecticut

17 NAME OF FATHER Herman Mugler

18 BIRTHPLACE OF FATHER (City) Germany
(State or country)

19 MAIDEN NAME OF MOTHER Hermine Mommendey

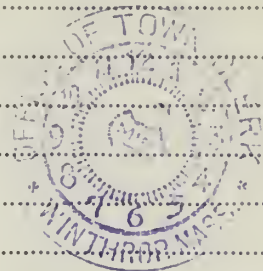
20 BIRTHPLACE OF MOTHER (City) Germany
(State or country)Informant Hermine G. Teixeira
(Address) 24 Spring St. MansfieldI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

J. O. Feb. 1, 1961
(Official Designation) (Date of Issue of Permit)

(Registrar)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RECEIVED
 FEB - 2 1961 PM
 RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its agent

00338

PLACE OF DEATH

Suffolk

(County)

Brighton

(City or Town)

No.

St. Elizabeth's Hosp.

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

Registered No.

STANDARD
CERTIFICATE OF DEATH

2 FULL NAME

Francis E. Lynch

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) WW #1

(a) Residence. No.

168 Bartlett Road

St.

Winthrop

(Usual place of abode)

8 hrs.

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. days. In place of residence. 45 years. months. days.

INSTRUCTIONS
FOR
LEGAL CERTIFICATEIn giving
STATE OF DEATHdo not enter
more than one
cause for each
a), (b) and (c)does not mean
mode of dying,
as heart failure,
etc. It means
disease, or compli-
cations which causedditions, if any,
which gave rise to
the cause (a),
including the under-
lying cause last.conditions contrib-
uted to death but not
led to the terminal
condition givenChapter 137,
of 1954, requires
physicians to print or
the cause or
of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

B 20 1961

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 11 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
1-11 1961, to 1-11 1961I last saw him alive on 1-11 1961, death is said to
have occurred on the date stated above, at 8:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Chronic Duodenal ulcer

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To (b) massive hemorrhage

Due To (c) Myocardial infarct, recent

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed) John P. Santos, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) St. Elizabeth's Hosp. Date 1-12 1961

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 14, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS 79 Atlantic St. Winthrop

Received and filed

JAN 17 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: Finance U.S. Government

15 Social Security No. NONE

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER John E. Lynch

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Mary A. Flynn

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant John E. Lynch, Jr.
(Address) 168 Bartlett Rd WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Jacqueline Casey
(Signature of Agent of Board of Health or other)A 00335 1-12-61
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles E. Proctor

RECEIVED



FEB 20 1961 AM

SUFFOLK

BOSTON

PLACE OF DEATH

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No.

00570

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, None
(if so specify WAR)

2 FULL NAME Thomas R. O'Connor

(If deceased in a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 184 Somerset Avenue
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1 days. In place of residence.....1 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 16 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That deceased died on
January 15 1961 to January 16 1961I last saw him alive on January 16 1961, death is said to
have occurred on the date stated above, at 4:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Aspiration of Blood into
LUNGSDue To ESOPHAGEAL VARICES
(b)Due To LAENNEC'S CIRRHOSIS
(c)INTERVAL
BETWEEN
ONSET AND
DEATH

mts

yrs

16 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Ch. Clay, M. D.

Charles L. Clay, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Jan. 16 1961

6 Winthrop Winthrop Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 19 1961

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St. Winthrop Mass

Received and filed JAN 19 1961

Charles J. Znachek

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)
MARRIED Married
WIDOWED or DIVORCED

10a If married, with HUSBAND of Jane F. Baumeister

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here

12 AGE 54 Years 5 Months 8 Days If under 24 hours
Hours Minutes13 Usual Occupation: Machine Operator
(Kind of work done during most of working life)

14 Industry or Business: Marine Hardware

15 Social Security No. 025-01-4418

16 BIRTHPLACE (City) Boston, Mass
(State or country)

17 NAME OF FATHER Thomas O. Connor

18 BIRTHPLACE OF FATHER (City) Boston, Mass
(State or country)

19 MAIDEN NAME OF MOTHER Rosella Doherty

20 BIRTHPLACE OF MOTHER (City) Boston, Mass
(State or country)21 Informant Mrs. Jane O'Connor
(Address) 184 Somerset Ave, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATE

PLACE OF DEATH

Do not enter
more than one
for each
(b) and (c)Do not mean
of dying,
heart failure,
etc. It means
of or compli-
which causedDo not mean,
if any,
gave rise to
cause (a),
the under-
cause last.Do not contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
to print or
cause or
death on
ificates, and
48, Acts of
quirea Phys-
print or type
er signature

R-301A

use only

K Ink.

M.C.

39-92566

U.S. DEPT. OF JUSTICE

Handwritten signature

Handwritten text

RECEIVED



MAR - 6 1961 AM

Suffolk

(County)

Boston

(City or Town)

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent. 27STANDARD
CERTIFICATE OF DEATH

Registered No. 00679

PLACE OF DEATH

No. ST. ELIZABETH'S HOSPITAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME

ANTONETTA Famiglietti
ANTOINETTE FAMIGLIETTI

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 24 TILESTON ROAD
(Usual place of abode)St. WINTHROP
(If nonresident, give city or town and State)

Length of stay: In place of death, years months 10 days In place of residence 14 years months days.

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATEIN GIVING
OF DEATHnot enter
more than one
cause for each
(b) and (c)does not mean
death of dying,
heart failure,
etc. It means
cause, or compli-
cation which causedconditions, if any,
gave rise to
cause (a),
or the under-
cause last.conditions contrib-
uted to death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
ificates, and
48, Acts of
quires Physl-
print or type
der signature.

m.c.

JAN 6 1961

6-59-925686

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 20 1961
(Month) (Day) (Year)I HEREBY CERTIFY, That attended deceased from
JAN 10, 1961, to JAN. 20, 1961I last saw her alive on JAN 20, 1961, death is said to
have occurred on the date stated above, at 6:05 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CONGESTIVE HEART FAILURE

Due To MYO CARDIAL INFARCTION
(b)Due To CORONARY HEART DISEASE
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) Robert S. Letteney, M.D.
ROBERT S. LETTENY
(PRINT OR TYPE SIGNATURE)

(Address) ST. ELIZABETH Boston 1/20/61

6 St. Michael's Boston Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 23 1961

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St Winthrop Mass

Received and filed JAN 22 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED married10a If married, widowed, or divorced
HUSBAND of(Give maiden name of wife in full)
(or) WIFE of Raffaele Famiglietti
(Husband's name in full)

11 IF STILL BORN, enter that fact here

12 AGE 71 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. NINE

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Antonia Salerno

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Marie Conti

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant (Address) Mr Joseph A Famiglietti
Court Rd, Winthrop MassI HEREBY CERTIFY that a satisfactory standard certificate of death
was issued with me BEFORE the burial or transfer permit was issued:
(Signature of Agent of Board of Health or other)A14418 Jan 22 1961
(Official Designation) (Date of Issue of Permit)

RECEIVED



MAR - 6 1961 AM

15 aumen

FORM R-301A

INSTRUCTIONS
FOR
VITAL CERTIFICATEIn giving
STATE OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)s does not mean
mode of dying,
as heart failure,
etc. It means
cause or compli-
s which causedditions, if any,
ch gave rise to
ve cause (a),
ing the under-
g cause last.conditions contrib-
to death but not
to the terminal
condition givenChapter 137,
f 1954, requires
ians to print or
the cause or
of death on
certificates, and
r 48, Acts of
requires Physi-
to print or type
under signature.

MAR 6 1961

11-59-926662

PLACE OF DEATH		The Commonwealth of Massachusetts		OUT - OF - TOWN 28	
Baptized Suffolk Brighton (City or Town)		JOSEPH D. WARD SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS		To be filed for burial permit with Board of Health or its Agent.	
No. Saint Elizabeths Hospital		STANDARD CERTIFICATE OF DEATH		Registered No. 1133	
2 FULL NAME Baby Boy Colpak		(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)		PHYSICIAN — IMPORTANT	
(If deceased is married, widowed or divorced woman, give also maiden name.)		150 Locust		(Was deceased a U. S. War Veteran, if so specify WAR) No	
(a) Residence. No. 150 Locust		St. Winthrop, Mass		(If nonresident give city or town and State)	
Length of stay: In place of death.....years.....months.....days.		In place of residence.....years.....months.....days.			
MEDICAL CERTIFICATE OF DEATH					
3 DATE OF DEATH JAN 31 1961		PERSONAL AND STATISTICAL PARTICULARS			
(Month) (Day) (Year)		8 SEX Male		9 COLOR white	
4 I HEREBY CERTIFY, That I attended deceased from JAN 31 19 61 to JAN 31 19 61		10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED single			
I last saw him alive on JAN 31 19 61, death is said to have occurred on the date stated above, atm.		10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)			
DEATH WAS CAUSED BY: IMMEDIATE CAUSE		INTERVAL BETWEEN ONSET AND DEATH 1 hr.		(or) WIFE of (Husband's name in full)	
(a) Atelectasis		11 IF STILLBORN, enter that fact here.			
Due To (b) Prematurity		12 AGE.....Years.....Months.....Days		If under 24 hoursHours.....Minutes	
Due To (c)		13 Usual Occupation: (Kind of work done during most of working life)			
OTHER SIGNIFICANT CONDITIONS		14 Industry or Business:			
Was autopsy performed? No		15 Social Security No.			
What test confirmed diagnosis?		16 BIRTHPLACE (City) Brighton, Mass (State or country)			
5 Was disease or injury in any way related to occupation of deceased? No		17 NAME OF FATHER Donald Colpak			
If so, specify		18 BIRTHPLACE OF FATHER (City) Newton, Mass (State or country)			
(Signed) Jacques Desrosiers, M. D. (PRINT OR TYPE SIGNATURE)		19 MAIDEN NAME OF MOTHER Claire Walsh			
(Address) St. Elizabeths Hosp. Date 1/31/61		20 BIRTHPLACE OF MOTHER (City) Medford, Mass. (State or country)			
6 Pl. Benedict Cemetery West Roxbury Place of Burial or Cremation (City or Town)		21 Informant (Address) St. Elizabeths Hospital Brighton			
DATE OF BURIAL 7/26/61		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: (Signature of Agent of Board of Health or other)			
7 NAME OF FUNERAL DIRECTOR William F. Walsh		625		3/1/61	
ADDRESS 20 High St. Waltham		(Official Designation)		(Date of Issue of Permit)	
Received and filed FEB 8 1961		(Registrar)			

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



MAR - 6 1961 AM

B.-THIS IS A
ANENT RECORD.
Use only
TE APPROVED
ck ink or black
ewriter ribbon.

INSTRUCTIONS
FOR
CAL CERTIFICATE

In giving
E OF DEATH

Do not enter
re than one
se for each
(a) and (c)

Does not mean
ode of dying,
is heart failure,
n, etc. It means
case, or compli-
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itions, if any,
gave rise to
cause (a).
g the under-
cause last.

ditions contrib-
to death but not
to the terminal
condition given

Chapter 137,
1954, requires
ans to print or
he cause or
of death on
ificates.

HAP. 46, § 9 &
IAP. 114, § 45,

HAP. 381A,
R 6 1961

al Director

se use only
CK Ink.

The Commonwealth of Massachusetts

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 01070

Massachusetts General Hospital BAKER MEMORIAL
No. Ladd

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME VIRGINIA FLISTER (Godfrey)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 175 Bartlett Rd., St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 1 months 5 days. In place of residence 44 years 5 months 27 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 28, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
December 22, 60, to January 28, 1961
I last saw her alive on January 28, 1961, death is said to
have occurred on the date stated above, at 11:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GASTROINTESTINAL
HEMORRHAGE

Due To Acute Myelocytic
(b) LEUKEMIA

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles L. Clay, M.D.
(Address) Asst. Dir., Mass. Gen. Hosp. Date 1-28-61

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 31, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 2 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED married
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Roy Milton Flister
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 44 Years 5 Months 27 Days If under 24 hours
Hours Minutes

13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 011-01-2256

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

17 NAME OF FATHER George Jason Godfrey

18 BIRTHPLACE OF FATHER (City) Northwood Ctr.,
(State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Winnifred Ladd

20 BIRTHPLACE OF MOTHER (City) Mercer
(State or country) Maine

21 Informant Roy M. Flister
(Address) 175 Bartlett Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

595 1/31/61
(Official Designation) (Date of Issue of Permit)

Handwritten text, possibly a date or reference number, is faintly visible in the upper left corner.

RECEIVED



MAR - 6 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. **30**

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. **131 Terrace Avenue**{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME **James Conrad Nelson**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
(if so specify WAR) NO.(a) Residence. No. **12 River Road**
(Usual place of abode)St. _____
(If nonresident, give city or town and State)Length of stay: In place of death.....years.....months **14** days. In place of residence **34** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **February 5 1961**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
December 58, 19....., to....., 19.....
I last saw him alive on **18 Jan**, 19**61**, death is said to
have occurred on the date stated above, at **2:45 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Carcinomatosis**INTERVAL
BETWEEN
ONSET AND
DEATH**6 mo**Due To **Carcinoma of esophagus**
(b)**3 yrs**Due To _____
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? **no**
What test confirmed diagnosis? **operative removal**5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____(Signed) **Arthur C. Murray**, M.D.**Arthur C. Murray, M.D.**
(PRINT OR TYPE SIGNATURE)(Address) **Winthrop** Date **7 Feb**, 19**61**6 **Winthrop Cemetery Winthrop, Mass.**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **February 8, 1961**7 NAME OF FUNERAL DIRECTOR **John B. Ward**ADDRESS **174 Winthrop St. Winthrop, Mass.**Received and filed **FEB 8 1961**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED **widowed**
WIDOWED
or DIVORCED10a If married, widowed, or divorced,
HUSBAND of **Ragnhild Olivier Jakabsen**
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **69** Years **10** Months **20** Days
If under 24 hours
.....Hours.....Minutes13 Usual Occupation: **self employed**
(Kind of work done during most of working life)14 Industry or Business: **paint and paper hanger**15 Social Security No. **030-10-7944**16 BIRTHPLACE (City) **Tonsberg**
(State or country) **Norway**17 NAME OF FATHER **Yohan Nillssen Bjune**18 BIRTHPLACE OF FATHER (City) **Ramnes**
(State or country) **Norway**19 MAIDEN NAME OF MOTHER **Karen Yoneyang**20 BIRTHPLACE OF MOTHER (City) **Ramnes**
(State or country) **Norway**Informant **Mrs. George M. Ogle**
(Address) **131 Terrace Ave. Winthrop**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

HO any **Feb. 8 - 1961**
(Official Designation) (Date of Issue of Permit)

R-301A

CTIONS
OR
CERTIFICATEgiving
OF DEATHnt enter
than one
for each
b) and (c)es not mean
of dying,
heart failure,
tc. It means
or compli-
which causedns, if any,
ve rise to
ause (a),
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ause last.ions contrib-
eath but not
the terminal
dition givenChapter 137,
54, requires
s to print or
cause or
death on
ificates, and
18, Acts of
quires Physi-
rint or type
signature.

SPACE FOR ADDITIONAL INFORMATION.....RECEIVED

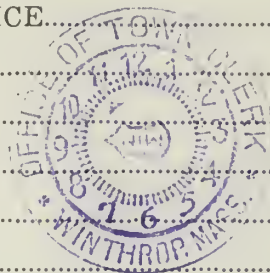
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



FEB 16 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 31

PLACE OF DEATH

Vinthrop
(City or Town)

No. 101
Hoyflower Murin Home

{If death occurred in a hospital or institution,
St. { give its NAME instead of street and number}

PHYSICIAN - IMPORTANT

2 FULL NAME William Franklin Keith

{(Was deceased a
U. S. War Veteran, No
(if so specify WAR)

(a) Residence. No. 110 Grovers Avenue St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years 4 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 6, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct. 1, 1960, to Feb. 6, 1961
I last saw him alive on Feb. 6, 1961, death is said to
have occurred on the date stated above, at 8 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cardiac decubitus on 6/10

INTERVAL
BETWEEN
ONSET AND
DEATH

1-25
61

Due To (b) arteriosclerotic heart disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS
Decubitus rt heel

2 no

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify no

(Signed) A. H. Caplan, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 105 Princeton St. Date 2-7, 1961

6 Forest Hills Crematory Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 9, 1961

7 NAME OF FUNERAL DIRECTOR The Bell Funeral Home, Inc.
ADDRESS 316 St. Brookline, Mass.

Received and filed FEB 7 1961

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED MARRIED WIDOWED WIDOWED
or DIVORCED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Florence C. MBI
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 4 Months 3 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Liquor wholesales
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. none

16 BIRTHPLACE (City) Crossona,
(State or country) Penn.

17 NAME OF FATHER Phineas Keith

18 BIRTHPLACE OF FATHER (City)
(State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Sara Moses

20 BIRTHPLACE OF MOTHER (City)
(State or country) Penn.

21 Informant Mrs. Albert C. Aldrich
(Address) 24 University Rd. Brookline

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with the BEEFORE the burial or transit permit was issued:

Ralph E. Schuman
(Signature of Agent of Board of Health or other)

7.0. (Official Designation) Feb. 7/1961 (Date of Issue of Permit)

(Registrar)

R-301A

DUCTIONS
OR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
b) and (c)

as not mean
of dying,
early failure,
etc. It means
or compli-
which caused

as, if any,
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ause (a),
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ions contrib-
death but not
the terminal
dition given

Chapter 137,
54, requires
to print or
cause or
death on
ificates, and
8, Acts of
ires Physi-
rint or type
signature.

59-925686

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

FEB 7 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING RECEIVED

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

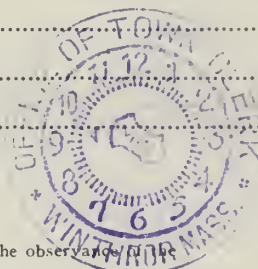
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

33

No. Danvers State Hospital, Hathorne, Mass. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arthur F. Wrightson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR. No

(a) Residence, No. 35 Summit Avenue
(Usual place of abode)

// Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years. 11 months. 2 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 11, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from March 9, 1960 to February 11, 1961
I last saw him live on February 11, 1961 death is said to

have occurred on the date stated above, at 4:20a.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized Arteriosclerosis
years(b) ~~xxx~~ & Arteriosclerotic Heart
disease yearsDue To
(c)OTHER
SIGNIFICANT
CONDITIONS Secondary AnemiaWas autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) Andrew Nichols III M. D.
Hathorne, Mass. Date 2/11/ 616 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 15, 61

7 NAME OF FUNERAL DIRECTOR Alfred Marsh
Winthrop, Mass.

ADDRESS

Received and filed MAR 8 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widowed

10a If married, widowed, or divorced HUSBAND of Charlotte Westley
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 7 Months 20 Days If under 24 hours Hours Minutes

13 Usual Occupation: Architectual Engineer
(Kind of work done during most of working life)

14 Industry or Business: Unknown

15 Social Security No. Unknown

16 BIRTHPLACE (City) England
(State or country)

17 NAME OF FATHER Unknown

18 BIRTHPLACE OF FATHER (City) Unknown
(State or country) England

19 MAIDEN NAME OF MOTHER Unknown

20 BIRTHPLACE OF MOTHER (City) Unknown
(State or country) England21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY

ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED February 20, 1961

RECEIVED



MAR - 8 1961 4H

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

34

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 126 Brookfield Rd,

STANDARD
CERTIFICATE OF DEATH

Registered No. 34

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Rose Di Vita (Lampasona)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 126 Brookfield Rd.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 10 years months days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 16 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw him alive on 19, death is said to
have occurred on the date stated above, at 11 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To (b) Presumably Coronary Occlusion

Due To (c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? no
What test confirmed diagnosis? post mortem judgement5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray, M. D.

Arthur C. Murray

(PRINT OR TYPE SIGNATURE)

(Address) Winthrop Brookfield Rd. Date 17 Feb 1961

6 Winthrop Winthrop Mass

Place of Burial or Cremation

DATE OF BURIAL Feb 20 1961

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
ADDRESS 147 Winthrop St, Winthrop.

Received and filed FEB 20 1961 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed10a If married, widowed, or divorced
HUSBAND of Frank Di Vita (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 60 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)14 Industry or Business: At Home
none

15 Social Security No.

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Joseph Lampasona

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Anna Unknown

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Carmine Di Vita
(Address) Morton St Winthrop MassI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

(Registrar)

V.B.

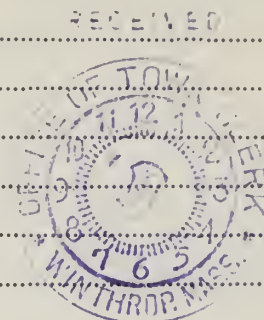
R-301A

DUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
b) and (c)es not mean
of dying,
heart failure,
tc. It means
or compli-
which causedns, if any,
ave rise to
ause (a),
the under-
ause last.ions contrib-
death but not
the terminal
dition givenChapter 137,
54, requires
s to print or
cause or
death on
ificates, and
8, Acts of
quires Physi-
print or type
signature.

C.

59-925686

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

FEB 20 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 35

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 81 Washington Avenue

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Herbert Newell Ridgway

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
(if so specify WAR) NO.(a) Residence. No. 81 Washington Avenue
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death. 63 years months days. In place of residence. 63 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 16 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
January 1960 to Feb. 16 1961
I last saw him alive on Feb. 16 1961, death is said to
have occurred on the date stated above, at 10:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Broncho pneumonia
(terminal)INTERVAL
BETWEEN
ONSET AND
DEATH

48 hrs

Due To Coronary artery
(b) diseaseDue To arteriosclerosis
(c) generalizedOTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Joseph G. Grogan, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 194 Washington Ave. Date 2/17 1961

6 Mount Auburn Cemetery Cambridge,
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 18, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 17 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED Married
WIDOWED
or DIVORCED

Male

White

10a If married, widowed or divorced
HUSBAND of Madeline Cecelia Clarke
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 0 Months 2 Days
If under 24 hours Hours Minutes13 Usual Occupation: retired inventor of beach
(Kind of work done during most of working life)

14 Industry or Business: amusement devices

15 Social Security No. 029-01-3553-A

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Charles Lowell Ridgway

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Harriet Eliza Cross

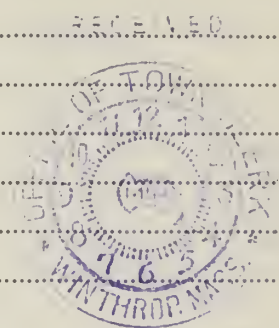
20 BIRTHPLACE OF MOTHER (City) Cambridge
(State or country) Massachusetts21 Informant Mrs. Herbert N. Ridgway
(Address) 95 Gordon St. Apt. 9. BrightonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Mass. Ralph E. Sullivan
(Signature of Agent of Board of Health or other)H. C. Feb. 17, 1961
(Official Designation) (Date of Issue of Permit)

R-301A

CTIONS
OR
CERTIFICATEiving
OF DEATHt enter
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for each
b) and (c)s not mean
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early failure,
tc. It means
or compli-
which causeds, if any,
ve rise to
ause (a),
he under-
use last.ions contrib-
path but not
the terminal
dition givenChapter 137,
54, requires
s to print or
cause or
death on
ificates, and
8, Acts of
quires Physi-
rint or type
signature.

59-925686

SPACE FOR 'ADDITIONAL INFORMATION'.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

FEB 17 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk
(County)Revere
(City or Town)

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Reverse

(City or town making return)

Registered No. 36

No. 38 North Avenue (If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

2 FULL NAME Felice Bomarsi (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 393 Main St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 21, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary occlusion

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19.

If accidental, was injury causally related to the death?

Where did injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of injury (How did injury occur?)

Nature of injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.

(Address) Boston Date 2/21 1961

7 Winthrop Cemetery, Winthrop (City or Town)

DATE OF BURIAL February 24, 1961

8 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed Feb. 23, MAR 8 1961 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Married

11a If married, widowed, or divorced HUSBAND of Rita DeMaio (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 71 Years 4 Months 11 Days If under 24 hours Hours Minutes

14 Usual Occupation: Contractor (Kind of work done during most of working life)

15 Industry or Business: Building

16 Social Security No.

17 BIRTHPLACE (City) Rome (State or country) Italy

18 NAME OF FATHER Erineo Bomarsi

19 BIRTHPLACE OF FATHER (City) Rome (State or country) Italy

20 MAIDEN NAME OF MOTHER Maria Carnesi

21 BIRTHPLACE OF MOTHER (City) Rome (State or country) Italy

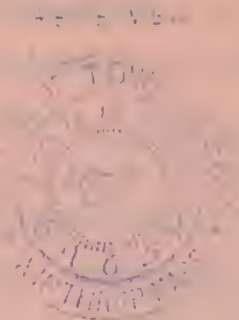
22 Informant Mrs. Rita Bomarsi (Address) 393 Main St., Winthrop

A TRUE COPY.

ATTEST: (Registered in City or Town where death occurred)

February 23, 1961

DATE FILED 19.



SPACE FOR ADDITIONAL INFORMATION MAR - 8 1961 AH

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 37

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 95 LORING RD

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME

JOHN M. NORRIS

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(If deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence. No.

95 LORING RD

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 20 years.....months.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

February 22, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
February 8, 1961, to February 22, 1961.
I last saw him alive on February 22, 1961, death is said to
have occurred on the date stated above, at 9:10 a.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

1 month

(b) Due To Primary carcinoma in right
lung

1 year

(c) Due To

OTHER
SIGNIFICANT
CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? X-ray of lung

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) John F. Collins, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 27 Bennington St. Date Feb. 24, 1961
Revere, Mass.6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 27 1961

7 NAME OF
FUNERAL DIRECTOR MADRICE W. KIRBY

ADDRESS WINTHROP

Received and filed FEB 27 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MALE

WHITE

MARRIED
WIDOWED
or DIVORCED MARRIED

10a If married, widowed or divorced

HUSBAND of IRENE NORRIS
(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 79 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: MOTORMAN
(Kind of work done during most of working life)

14 Industry

or Business: M. T. H.

15 Social Security No.

16 BIRTHPLACE (City)
(State or country)

LYNN MASS

17 NAME OF
FATHER

JOHN NORRIS

18 BIRTHPLACE OF

FATHER (City)

(State or country) N. H.

19 MAIDEN NAME

OF MOTHER

ANNE RILEY

20 BIRTHPLACE OF

MOTHER (City)

(State or country) N. H.

21

Informant
(Address)MRS IRENE NORRIS
95 LORING RD WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Jeremiah
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

V.B.V.

1 R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
e for each
(b) and (c)oes not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.itions contrib-
death but not
to the terminal
condition givenChapter 137,
954, requires
to print or
e cause or
f death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

1-59-92662

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

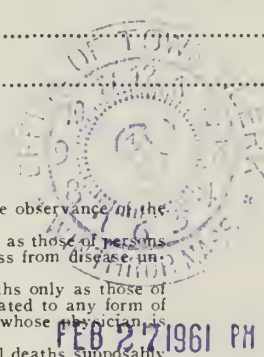
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 38

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 914 Shirley Street

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Wiggo Christian Williams <C.O.>
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran,
{if so specify WAR) NO.(a) Residence. No. 914 Shirley Street
(Usual place of abode) St.

(If nonresident, give city or town and State)

Length of stay: In place of death 65 years months days. In place of residence 65 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 24 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
now 1956 to Feb 24 1961
I last saw him alive on Feb 24 1961, death is said to
have occurred on the date stated above, at 7:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

INTERVAL
BETWEEN
ONSET AND
DEATH

30/95

Due To (b) Atherosclerosis

Due To (c) cerebral.

OTHER
SIGNIFICANT
CONDITIONS none

Was autopsy performed? clinical

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles E. Williams, M.D.

CHARLES E. WILLIAMS, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 114 Winthrop St. Date 2/28/1961

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 28 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 1 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED widowed WIDOWED or DIVORCED

10a If married, widowed or divorced HUSBAND of Laura Christafsen
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 95 Years 0 Months 3 Days If under 24 hours Hours Minutes

13 Usual Occupation: retired oiler
(Kind of work done during most of working life)

14 Industry or Business: Deer Island Pumping Station

15 Social Security No. none

16 BIRTHPLACE (City) Oslo
(State or country) Norway

17 NAME OF FATHER John Knudsen

18 BIRTHPLACE OF FATHER (City) Oslo
(State or country) Norway

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) Oslo
(State or country) NorwayInformant George T. Williams
(Address) 914 Shirley St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

H.C. 2-28-3/1/61

(Official Designation) (Date of Issue of Permit)

R-301A

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CERTIFICATEiving
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59-925686

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



MAR - 1 1961 TM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

N. B.—WRITE PLAINLY WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 34, §§ 4, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. Veteran, (G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

504-6-60-9281/5

PLACE OF DEATH

Suffolk
(County)
Boston
(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

OUT - OF - TOWN

39

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 111860

Massachusetts General Hospital

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME KENNETH KELLY
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 30 Atlantic Street
(Usual place of abode)

St. Winthrop, Mass.

Length of stay: In place of death 2 years 23 months 5 days. In place of residence 2 years 5 months 9 days. (If nonresident, give city or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 21 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)

Blunt force injury of head with
bilateral subdural hematoma and
cerebral contusion.

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 2-19 1961

IF ACCIDENTAL, was injury causally related to the death? Yes

Where did
Injury occur? Boston, Mass.
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place? Public highway
(Specify type of place)

Manner of
Injury Pedestrian struck by motor car
(How did injury occur?)

Nature of
Injury

While at work? Was autopsy performed No

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Michael A. Luongo, M. D.
(Print or Type Signature)

(Address) Boston, Mass. Date 2-22 1961

7 Winthrop Winthrop
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Feb. 24 1961

8 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed FEB 24 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)
MARRIED Single
WIDOWED
or DIVORCED

11a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 23 5 9
Years Months Days If under 24 hours
Hours Minutes

14 Usual Occupation: Soldier
(Kind of work done during most of working life)

15 Industry or Business: U S Army

16 Social Security No. 031-28-4831

17 BIRTHPLACE (City) Winthrop
(State or country) Mass

18 NAME OF FATHER William K Kelly

19 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass

20 MAIDEN NAME OF MOTHER Althea W Pratt

21 BIRTHPLACE OF MOTHER (City) Somerville
(State or country) Mass

22 Informant William K Kelly
(Address) 105 Chestnut St. N Reading

1 HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) 936 (Date of Issue of Permit) 2/23/61

VIV

A TRUE COPY ATTEST:

Charles H. Mackie

Notary Public

RECEIVED



MAR 22 1961 AM

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-4-59-926111

PLACE OF DEATH

Middlesex
(County)
Cambridge
(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Cambridge
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. **320**

No. **Guardian Hospital 85 Otis St. Camb.** (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME **Michael Burke**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. **9 Atlantic St.** St. **Winthrop, Mass.**
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death **20** years **10** months **10** days. In place of residence **10** years **10** months **10** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **March 3, 1961**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **Feb. 11, 1961** to **Mar. 3, 1961**
I last saw him alive on **March 3, 1961** death is said to have occurred on the date stated above, at **2:30p.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebellar Metastases**

Due To (b) **Carcinoma of the Lung**

Due To (c) _____

OTHER SIGNIFICANT CONDITIONS _____

Was autopsy performed? **yes**
What test confirmed diagnosis? **Biopsy**

5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____

(Signed) **Francis E. Smith**, M. D.
(Address) **85 Otis St. Camb. Mar. 3, 1961**

6 **Winthrop Cemetery Winthrop**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **March 6, 1961**

7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**
ADDRESS **79 Atlantic St. Winthrop**

Received and filed **APR 11 1961** 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word) **Married**
MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced, HUSBAND of **Nora Kennedy**
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **53** Years **53** Months **53** Days
If under 24 hours _____ Hours _____ Minutes

13 Usual Occupation: **Heat Checker**
(Kind of work done during most of working life)

14 Industry or Business: **First National Stores**

15 Social Security No. _____

16 BIRTHPLACE (City) **Cty. Galway, Ireland**
(State or country)

17 NAME OF FATHER **Patrick Kennedy**

18 BIRTHPLACE OF FATHER (City) **Cty. Galway, Ireland**
(State or country)

19 MAIDEN NAME OF MOTHER **Kate Mellody**

20 BIRTHPLACE OF MOTHER (City) **Cty. Galway, Ireland**
(State or country)

Informant **Nora Burke**
(Address) **9 Atlantic St. Winthrop**

A TRUE COPY **Frederick H. Burke**

ATTEST: _____
(Registrar of City or Town where death occurred)

DATE FILED **Mar. 7, 1961**

V.B.V.

RECEIVED



SPACE FOR ADDITIONAL INFORMATION APR 11 1961 AM

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 41

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Anna C. Campbell
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence, No. 156 Somerset Ave. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 8 days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 3, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to March 3, 1961
I last saw him alive on March 3, 1961, death is said to
have occurred on the date stated above, at 7:40 P. M.INTERVAL
BETWEEN
ONSET AND
DEATH
1 1/2 hr

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute left + ventric

Due To avar Failure

(b) arteriosclerotic yrs

Due To heart Disease

(c) arteriosclerosis-gen yn

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph D. Ward, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 194 Washington Ave. Date 3/4 1961

6 Glenwood Everett Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 7 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
Winthrop Mass

ADDRESS

Received and filed MAR 6 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Archibald F. Campbell
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston Mass
(State or country)

17 NAME OF FATHER Olaus Olson

18 BIRTHPLACE OF FATHER (City) Sweden
(State or country)

19 MAIDEN NAME OF MOTHER Carlotta Krona

20 BIRTHPLACE OF MOTHER (City) Sweden
(State or country)21 Informant Hazel MacDonald
(Address) 156 Somerset Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sullivan
(Signature of Agent of Board of Health or other)

H. O. (Official Designation) 3/6/61 (Date of Issue of Permit)

R-301A

CTIONS
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CERTIFICATEiving
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SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



THIS IS A
CERTIFICATE OF DEATH
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APPROVED
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FOR
CERTIFICATE

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OF DEATH

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54, requires
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death on
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P. 46, §§ 9 &

P. 114 §§ 45,

P. 38 § 6.)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 42

No. 246 Shore Drive, Winthrop St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Samuel Weiner
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 246 Shore Drive St. Winthrop Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 14 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 3rd 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
October, 1952 to March 3, 1961
I last saw him alive on March 2, 1961, death is said to
have occurred on the date stated above, at 9:10 A.M.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion
acute

Due To Coronary Artery Heart
(b) Disease. 10yrs

Due To Arteriosclerosis. 5yrs.
(c)

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify Charles Liberman

(Signed) Charles Liberman, M. D.

(Address) Winthrop, Mass. Date 3/3/1961

6 Bessarabian Cem Everett Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 5th 1961

7 NAME OF FUNERAL DIRECTOR Philip Briss
ADDRESS 470 Harvard Street, Bklyn Mass

Received and filed 3-3-61 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Tina Halpern
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: retail meats
(Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No.

16 BIRTHPLACE (City)
(State or country) Russia

17 NAME OF FATHER Morris Weiner

18 BIRTHPLACE OF FATHER (City)
(State or country) Russia

19 MAIDEN NAME OF MOTHER Hinda (unknown)

20 BIRTHPLACE OF MOTHER (City)
(State or country) Russia

21 Informant Mrs Tina Weiner
(Address) 246 Shore Drive, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with the BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

U.P.V.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

PLACE OF DELIVERY

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

St. }

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

Registered No. 43

2 NAME OF FETUS Baby Poy Buonopane
(if given)

3 DATE OF DELIVERY 3/5/61

(Month) (Day) (Year)

4 SEX X
Male.....Female.....Undetermined.....

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single X Twin.....Triplet7 IF MULTIPLE BIRTH, BORN:
1st.....2nd.....3rd.....

FATHER

8 FULL NAME Alberico Buonopane

9 RESIDENCE, NO. 1115 Saratoga St., STREET
CITY OR TOWN E. Boston STATE Mass.

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 40 (Years)

12 PLACE OF BIRTH Italy
(City or Town) (State or country)

13 OCCUPATION Candy Maker

MOTHER

14 MAIDEN NAME Florence Buonopane

PRESENT NAME Florence Buonopane

15 RESIDENCE, NO. 1115 Saratoga St., STREET
CITY OR TOWN E. Boston STATE Mass.

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 40 (Years)

18 PLACE OF BIRTH Italy
(City or Town) (State or country)

19 INFORMANT Alberico Buonopane

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

(a) How many children are now living? 6

(b) How many children were born alive but are now dead? 0

(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY about 20 completed weeks

22 WEIGHT OF FETUS Lb. 10 1/2 Oz.
(or Grams)

23 WHEN DID FETUS DIE? Before Labor During Labor or Delivery Unknown

24 AUTOPSY Yes.....No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) DIED in utero- Cause unknown.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 8, 6127 NAME OF FUNERAL DIRECTOR Vincent Rapino
ADDRESS 9 Chelsea St., East Boston

Received and filed MAR 8 1961

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 6 a.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

D. Thomas Staffier

M.D.

(PRINT OR TYPE SIGNATURE)

Address 19 Breed St., East Boston

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Linnann
Signature of Agent of Board of Health or other

(Official Designation)

(Date of Issue of Permit)

RECEIVED

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.Suffolk
(County)Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 44

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary J. Cardoza (Benavidz)

{(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

No

(a) Residence. No. 62 Cottage Avenue, Winthrop

(Usual place of abode)

St.

{(If nonresident, give city or town and State)

Length of stay: In place of death. Years. months. 5 days. In place of residence. 32 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 5 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
MAR 5 to MAR 5 1961I last saw her alive on MAR 5 1961, death is said to
have occurred on the date stated above, at 7:20 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH

2 WKS.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCIDENT
WITH RT HEMIPLEGIADue To (b) ARTERIO-SCLEROTIC + HYPER-
TENSIVE HEART DIS

5 YRS.

Due To (c)

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS - MILD
DECUBITUS ULCER

5 DAYS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Myron N. King, M.D.

MYRON N. KING M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 222 PLEASANT ST. Date 3/5 1961

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 8th 1961

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed MAR 6 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED

Widowed

10a If married, widowed, or divorced

HUSBAND of

{(Give maiden name of wife in full)

(or) WIFE of Matthew E. Cardoza
{(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 82 Years. 4 Months. 9 Days

If under 24 hours

Hours. Minutes

13 Usual

Occupation:

Housewife

{(Kind of work done during most of working life)

14 Industry

or Business:

At home

15 Social Security No.

No

16 BIRTHPLACE (City)

(State or country)

Azores

Portugal

17 NAME OF

FATHER

Manuel Benavidz

18 BIRTHPLACE OF

FATHER (City)

Azores

(State or country)

Portugal

19 MAIDEN NAME

OF MOTHER

Anna DeRego

20 BIRTHPLACE OF

MOTHER (City)

Azores

(State or country)

Portugal

21

Informant

(Address)

Miss Mary H. Cardoza - dau.

62 Cottage Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Schumann
{(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

V. H. H.

RECEIVED



SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

CERTIFICATE

DEATH

enter
an one
or each
) and (c)not mean
of dying,
ut failure,
It means
or compli-
ch causedif any,
rise to
se (a),
under-
se last.as contrib-
th but not
e terminal
ation givenChapter 137,
requires
o print or
cause or
death on
ates, and
Acts of
ues Physi-
nt or type
signature.

-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 45

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. Washington Rest Home -

St { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Joseph Delmonico
(If deceased is a married, widowed or divorced woman, give also maiden name.){ (Was deceased a
U. S. War Veteran, no
if so specify WAR)(a) Residence. No. 218 Lincoln Street
(Usual place of abode)St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 3 years. months days. In place of residence 6 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 8 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
May 1957 to March 8, 19611 last saw him alive on March 3, 1961, death is said to
have occurred on the date stated above, at 1:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart
disease(b) arterio sclerosis
generalized

(c) Senility

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Joseph P. Gregoire, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 194 East 111 St. N.Y.C.

6 Assumption Cemetery, Syracuse, N.Y.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 13, 1961

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 10 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED widowed10a If married, widowed, or divorced
HUSBAND of Catherine E. McDonald
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 92 Years 5 Months 28 Days
If under 24 hours
Hours Minutes13 Usual Occupation: Contractor
(Kind of work done during most of working life)

14 Industry or Business: Building

15 Social Security No. -

16 BIRTHPLACE (City) Salerno
(State or country) Italy

17 NAME OF FATHER Anthony Delmonico

18 BIRTHPLACE OF FATHER (City) Salerno
(State or country) Italy

19 MAIDEN NAME OF MOTHER Louise Tetore

20 BIRTHPLACE OF MOTHER (City) Salerno
(State or country) ItalyInformant Mrs. May C. Gaffney
(Address) 218 Lincoln St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 3/10/61

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED MAR 10 1961 6 RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 28 Taylor

2 FULL NAME Louisa DeStefano

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 28 Taylor
(Usual place of abode){(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 4 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 8 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
June 1955, to March 8 1961.
I last saw her alive on March 7, 1961, death is said to
have occurred on the date stated above, at 8:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral vascular
hemorrhageDue To
(b)

Hypertension

Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Marion G. Sabia, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 241 MAVERICK ST Date March 9 1961
East Boston6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 11, 1961

7 NAME OF FUNERAL DIRECTOR DiPietro & Vazza

ADDRESS 11 Henry St. East Boston

Received and filed MAR 10 1961

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 46

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 4 years.....months.....days.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Peter DeStefano
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Italy

17 NAME OF FATHER Rizabetto Clericuzio

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Carmela Ruggiero

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Dora Festa
(Address) 28 Taylor St. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit with
Board of Health or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

Registered No. 47

No. Winthrop Community Hospital

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS Morello, Male
(if given)3 DATE OF DELIVERY 3 11 1961
(Month) (Day) (Year)4 SEX
Male ☒ Female... Undetermined

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single... Twin... Triplet7 IF MULTIPLE BIRTH, BORN:
1st... 2nd... 3rd...8 FATHER
FULL NAME Morello, Angelo J.9 RESIDENCE, NO. 27 Ford STREET
CITY OR TOWN Revere STATE Mass

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 31 (Years)

12 PLACE OF BIRTH Boston, Mass. (City or Town) (State or country)

13 OCCUPATION Clothing worker

14 MOTHER
MAIDEN NAME Guinasso, Marie
PRESENT NAME Morello, Marie15 RESIDENCE, NO. 27 Ford STREET
CITY OR TOWN Revere STATE Mass.

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 23 (Years)

18 PLACE OF BIRTH Boston, Mass. (City or Town) (State or country)

19 INFORMANT Angelo Morello

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) NONE

(a) How many children are now living?

(b) How many children were born alive but are now dead?

(c) How many previous fetal deaths of ANY gestation age?

21 LENGTH OF PREGNANCY 24 completed weeks

22 WEIGHT OF FETUS 1 Lb. 7 Oz. (or... Grams)

23 WHEN DID FETUS DIE? Before Labor During Labor or Delivery Unknown

24 AUTOPSY Yes... No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Unknown

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 St. Michael Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 14, 1961. 19

27 NAME OF FUNERAL DIRECTOR Arthur S. Porcella
ADDRESS 876 Winthrop Ave., Revere

Received and filed 19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 7:04 a.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Sydney Ellis M.D.

(PRINT OR TYPE SIGNATURE)

Address 311 Commonwealth Ave., Boston 3/11/61

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scianm... (Signature of Agent of Board of Health or other)

H.O. 3/13/61
(Official Designation) (Date of Issue of Permit)

RECEIVED

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

Suffolk

(County)

Winthrop

(City or Town)

No. Win. Community Hospital

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 48

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS Baby Boy Plucker
(if given)3 DATE OF DELIVERY March 13 1961
(Month) (Day) (Year)4 SEX ☒ Male ☐ Female ☐ Undetermined

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin ☐ Triplet7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd

8 FATHER

FULL
NAME

Dennis Plucker

9 RESIDENCE, NO. 175 Shirley STREET
CITY OR TOWN Winthrop STATE Mass.10 COLOR OR RACE White 11 AGE AT TIME OF
THIS DELIVERY 23 (Years)12 PLACE OF BIRTH Lenox South Dakota
(City or Town) (State or country)

13 OCCUPATION Machinist

MOTHER

14 MAIDEN NAME Catherine Corso
PRESENT NAME Catherine Plucker15 RESIDENCE, NO. 175 Shirley STREET
CITY OR TOWN Winthrop STATE Mass.16 COLOR OR RACE White 17 AGE AT TIME OF
THIS DELIVERY 22 (Years)18 PLACE OF BIRTH Boston Mass.
(City or Town) (State or country)

19 INFORMANT DENNIS PLUCKER

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

Two

(a) How many children are
now living? 2(b) How many children were
born alive but are now
dead? 0(c) How many previous fetal
deaths of ANY gestation
age? None21 LENGTH OF
PREGNANCY 30
completed weeks22 WEIGHT OF FETUS
3 Lb. Oz.
(or Grams)23 WHEN DID FETUS DIE?
Before ☐ During Labor ☒
Labor or Delivery Unknown24 AUTOPSY
Yes ☐ No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity

Due To (b) Premature separation of
Due To (c) placenta; plus cord around
neckOTHER SIGNIFICANT
CONDITIONS Threat. Misc. 2 wks
prev. and 24 hrs. prev.26 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL MARCH 15 196027 NAME OF
FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed MAR 15 1961 19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 7:20AM and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

A. N. Caplan M.D.

A. N. Caplan M.D.
19 Mermaid Ave

Address Wintthrop Mass Date 3/13 1961

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with the BEFORE the burial or transit permit was issued:H. O. Lirian
Signature of Agent of Board of Health or otherH.O. March 15/61
(Official Designation) (Date of Issue of Permit)

RECEIVED



MAR 15 1961 AM

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48. ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

PLACE OF DEATH

Suffolk
(County)
Winthrop

(City or Town)

Mount's Convalescent Home

No. 104 Highland Ave. Winthrop

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

(Usual place of abode)

36 Coral Ave

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 50 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 14 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 1950, to March 14, 1961.

I last saw him alive on March 10, 1961, death is said to

have occurred on the date stated above, at 2:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) congestive heart failure

INTERVAL
BETWEEN
ONSET AND
DEATH

11 yrs.

Due To (b) arteriosclerosis

Due To (c)

OTHER SIGNIFICANT CONDITIONS Sensitivity

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased NO

If so, specify

H. B. Greenfield M. D.

(Signed) H. B. Greenfield M. D.

(Address) 114 Shirley St. Winthrop, Mass. Date 3-14-1961

6 Place of Burial or Cremation Calvary Cemetery Boston (City or Town)

DATE OF BURIAL April 17, 1961

7 NAME OF FUNERAL DIRECTOR William C. Jinn

ADDRESS 157 Maple St. Lynn

Received and filed. MAR 16 1961

(Registrar)

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 49

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED11a If married, widowed, or divorced
HUSBAND of Mary E. McDonald
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 approx Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Office Manager
(Kind of work done during most of working life)

14 Industry or Business Insurance

15 Social Security No. 7-01-2

16 BIRTHPLACE (City) Boston Mass
(State or country)

17 NAME OF FATHER unable to obtain

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER unable to obtain

20 BIRTHPLACE OF MOTHER Ireland
(State or country)21 Informant William Connor, nephew
(Address) 114 Shirley St. LynnI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and four-
te n, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

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The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No.

50

Suffolk
(County)Winthrop
(City or Town)No. Mayflower Nursing Home
Howard Dexter Sprague(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SPRAGUE, Howard Dexter
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence. No. 9 Surfside Road
(Usual place of abode)

Lynn, Mass

St. Lynn Mass
(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. 3 days. In place of residence. 71 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 16 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
March 1961, to March 13, 1961
I last saw him alive on March 13, 1961, death is said to
have occurred on the date stated above, at 8:40 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) coronary thrombosis

Due To (b) Coronary Arteriosclerosis

Due To (c) Generalized Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Anemia

Was autopsy performed? Yes
What test confirmed diagnosis? Physical Exam5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Arthur H. Bunting, M. D.
Arthur H. Bunting
(PRINT OR TYPE SIGNATURE)

(Address) 26 Bradford St. Lynn Date 3-16-61

6 Puritan Lawn Peabody Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 18 19617 NAME OF FUNERAL DIRECTOR William C. Goodrich
ADDRESS 128 Washington St. Lynn, Mass

Received and filed MAR 16 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Divorced
WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Blanche Livingston
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years 0 Months 9 Days
If under 24 hours
Hours Minutes13 Usual Occupation: Dipper
(Kind of work done during most of working life)

14 Industry or Business Gen. Elec. Co. River Works

15 Social Security No. 015-09-4147

16 BIRTHPLACE (City) Lynn
(State or country) Mass

17 NAME OF FATHER Albert E. Sprague

18 BIRTHPLACE OF FATHER (City) Albany
(State or country) New York

19 MAIDEN NAME OF MOTHER Carrie Jackson

20 BIRTHPLACE OF MOTHER (City) C/B/L.
(State or country) Maine21 Informant Harold D. Sprague
(Address) 9 Surfside Rd. Lynn MassI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

H. O. at March 16 - 1961
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

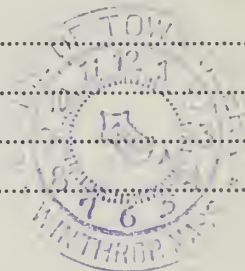
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ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATHRegistered No. **51**

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. **16 Bowdoin Street**(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME **John J. McCarthy**(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. **16 Bowdoin Street**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence **59** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **March 17 1961.**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
March 16, 19**61**, to **March 17**, 19**61**1 last saw him live on **March 17**, 19**61**, death is said to
have occurred on the date stated above, at **4:50 PM**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **sub arachnoid hemorrhage**INTERVAL
BETWEEN
ONSET AND
DEATH

1 day

(b) **ruptured cerebral aneurism**

1 day

(c) Due To

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? **no**What test confirmed diagnosis? **clinical**5 Was disease or injury in any way related to occupation of deceased **no**
If so, specify(Signed) **Charles Salemi** M. D.(PRINT OR TYPE SIGNATURE)
Charles Salemi MD(Address) **241 Main St.** Date **3/17/1961****Winthrop, Mass.**6 **Winthrop Cemetery** **Winthrop**
Place of Burial or Cremation (City or Town)DATE OF BURIAL **March 21**, 19**61**7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**ADDRESS **Winthrop Mass**Received and filed **MAR 20 1961**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male**White****MARRIED**
WIDOWED
or DIVORCED10a If married, widowed or divorced
HUSBAND of **Eva Kenney**

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

AGE **59**

Years.....Months.....Days

If under 24 hours
Hours.....Minutes

13 Usual

Occupation: **Attorney at Law**
(Kind of work done during most of working life)

14 Industry

or Business: **Law**

15 Social Security No.

16 BIRTHPLACE (City)
(State or country)**Winthrop**
Mass

17 NAME OF FATHER

John McCarthy

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER

Annie McDade

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21

Informant **Eva McCarthy**
(Address) **16 Bowdoin St., Winthrop**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 52

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)No. MAKFLOWER NURSING HOME St. (If death occurred in a hospital or institution,
{ give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME DIONISIOS KARAGIANIS
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 12 SEAFOAM AVE St. WINTHROP
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....8.....days. In place of residence 31.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 19 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from OCT 1951, to MARCH 19 1961
I last saw him alive on March 18, 1961, death is said to have occurred on the date stated above, at 7:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia Left Lung

INTERVAL
BETWEEN
ONSET AND
DEATH
36 hrsDue To
(b)Due To
(c)OTHER SIGNIFICANT CONDITIONS Cellulitis Rt. Leg 6 wks.
Cardiac Decompensation 2 days

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Charles Liberman D
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS Date 3/19/ 1961

6 PINEGROVE CEMETERY LYNN, MASS.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 21 1961

7 NAME OF FUNERAL DIRECTOR Fred C. Hanover

ADDRESS 1642 Commonwealth Ave. Boston

Received and filed MAR 20 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED10a If married, widowed or divorced
HUSBAND of ANASTASIA PAPATHANOS
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: SCRAP HELPER
(Kind of work done during most of working life)

14 Industry or Business: VARIETY

15 Social Security No. NONE

16 BIRTHPLACE (City) SPARTA
(State or country) GREECE

17 NAME OF FATHER ANASTASIS KARAGIANIS

18 BIRTHPLACE OF FATHER (City) GREECE
(State or country)

19 MAIDEN NAME OF MOTHER VASILINE GOUDOULE

20 BIRTHPLACE OF MOTHER (City) GREECE
(State or country)21 Informant GEORGE D. KARAGIANIS
(Address) 12 SEAFOAM AVE WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent or Board of Health or other

140 (Official Designation) March 20 - 1961 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No.

53

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Rose (Yavitz) Weiner

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence. No. 14 Wave Way Ave
(Usual place of abode)

St. Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death years months 2 days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 22 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Sept. 1950, to March 22 1961I last saw her alive on March 22, 1961, death is said to
have occurred on the date stated above, at 8:15 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion, acute

Due To Arteriosclerotic Heart
(b) DiseaseDue To
(c)OTHER
SIGNIFICANT
CONDITIONS NoneWas autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Charles Liberman M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP Date 3/23/1961

6 Golden Crown Lodge Woburn
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 23 19617 NAME OF FUNERAL DIRECTOR TORG Funeral Service Inc.
ADDRESS 151 Washington Ave Chelsea

Received and filed MAR 23 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Widowed
or DIVORCED10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Wolf Weiner
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Samuel Yavitz

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER CBL

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Eva B Gould
(Address) 14 Wave Way WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Silvanne
Signature of Agent of Board of Health or other)HO
(Official Designation)March 23-1961
(Date of Issue of Permit)

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SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

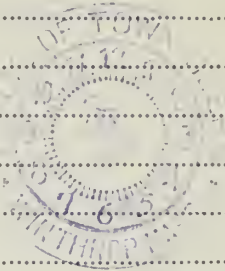
DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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MAR 2 3 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

Male Frost

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 90 Undine Avenue, Winthrop

(Usual place of abode)

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 23 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Mar. 23, 1961 to Mar. 23, 1961
I last saw him alive on Mar. 23, 1961 death is said to
have occurred on the date stated above, at 10.03 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity- 18 weeks

Due To (b) Prolapse of cord

Due To (c)

OTHER SIGNIFICANT CONDITIONS Club foot - rt.

Was autopsy performed? No Clinical & Lab.

What test confirmed diagnosis? No

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M. Traunstein, Jr., M.D.

M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Winthrop

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 24th 1961

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St., E. Boston

Received and filed MAR 24 1961

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No.

54

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Single

10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here. ~~Stillborn~~

12 AGE Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: None (Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Winthrop (State or country) Mass.

17 NAME OF FATHER Robert Frost

18 BIRTHPLACE OF FATHER (City) Portland (State or country) Maine

19 MAIDEN NAME OF MOTHER Laura Zawtsos

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant (Address) Mr. Robert Frost-father 90 Undine Ave., Winthrop, Mass.

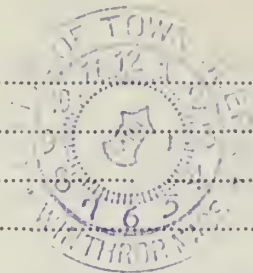
I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Seranni
(Signature of Agent or Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

X

RECEIVED



SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

MAR 24 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 55

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 226 Woodside Avenue

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

2 FULL NAME Oralie Marie Paul (Gagnon)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(a) Residence. No. 226 Woodside Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.14.....days. In place of residence.....years.....months.14.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 25 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
MAR. 20, 1961, to MAR. 25, 1961.

I last saw her alive on MAR 20, 1961, death is said to
have occurred on the date stated above, at 4:45 P.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial heart disease yrs.

Due To Arterio sclerosis, yrs.
(b) generalized

Due To Senility
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Joseph Gregorie, M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 194 Washington Ave. Mar. 27, 1961

6 St. Charles Cemetery Dover N.H.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 28, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS Winthrop, Mass.

Received and filed MAR 28 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED widowed
WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Narcisse Paul
(Husband's name in full)

11 IF STILLBORN, enter that fact here.
12 AGE 94 Years 6 Months 13 Days If under 24 hours
Hours Minutes

13 Usual Occupation: retired mill worker
(Kind of work done during most of working life)

14 Industry or Business: woolen mills

15 Social Security No. none

16 BIRTHPLACE (City) Canada
(State or Province)

17 NAME OF FATHER Louis Paul Gagnon

18 BIRTHPLACE OF FATHER (City) Canada
(State or country)

19 MAIDEN NAME OF MOTHER Emelienne Derosier

20 BIRTHPLACE OF MOTHER (City) Canada
(State or country)

21 Informant Mrs. Albert E. Olsen
(Address) 226 Woodside Ave. Winthrop

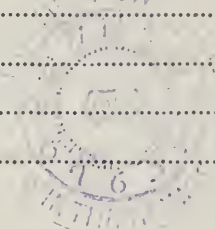
I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Williams
(Signature of Agent of Board of Health or other)

H.D. 3/28/61
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED

STOW



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MAR 28 1961 PM

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

COPY OF

CERTIFICATE OF DEATH

Registered No.

56

Danvers State Hospital, Hathorne, St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME, WINTER, Arthur H. (Also known as Henry Winters) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR. No

(a) Residence. No. 207 Winthrop Street, Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. 2 years. 9 months. 0 days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 25, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 25, 1958 to March 25, 1961

I last saw him alive on March 25, 1961 death is said to have occurred on the date stated above, at 4:40a.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis ? Pancreatic Primary Site Months 60

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Andrew Nichols III, M. D.

(Address) Hathorne, Mass. Date 3/25/61

6 Holy Cross Cemetery, Malden, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 28, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed APR 11 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Separated WIDOWED or DIVORCED

10a If married, widowed or divorced HUSBAND of Unknown (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE. 60 Years. 5 Months. 8 Days If under 24 hours Hours. Minutes

13 Usual Occupation: Painter (Kind of work done during most of working life)

14 Industry or Business: 025-03-3449

15 Social Security No. Revere, Mass.

16 BIRTHPLACE (City) (State or country) Mass.

17 NAME OF FATHER Arthur E. Winter

18 BIRTHPLACE OF FATHER (City) Peabody (State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Miller

20 BIRTHPLACE OF MOTHER (City) Unknown (State or country) Ireland

21 Informant (Address) Mary E. Sheehan Hathorne, Mass.

A TRUE COPY Daniel J. Toomey ATTEST: (Registrar of City or Town where death occurred)

DATE FILED April 4, 1961

RECEIVED



SPACE FOR ADDITIONAL INFORMATION APR 11 1961 AM
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 57

PLACE OF DEATH

SUFFOLK

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frank J. Fratas

(If deceased is a married, widowed or divorced woman, give also maiden name.)

((Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 27 Thornton Street
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months 2 days In place of residence 12 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 4 March 26 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19 to 19
I last saw him alive on 19, death is said to have occurred on the date stated above, at 8:30 a.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

Due To (b) Myocardial infarction

Due To (c) Myocardial infarction

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? 1

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? 1
If so, specify

(Signed) Joseph J. Kirby, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 917 Bennington St., E. Boston Date 3/27/61 1961

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 29th 1961

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St., E. Boston

Received and filed 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Married

10a If married, widowed, or divorced HUSBAND of Molly (CBL)
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 4 Months 8 Days If under 24 hours Hours Minutes

13 Usual Occupation: Candy maker
(Kind of work done during most of working life)

14 Industry or Business: Candy

15 Social Security No.

16 BIRTHPLACE (City) Portugal
(State or country)

17 NAME OF FATHER Joseph Fratas

18 BIRTHPLACE OF FATHER (City) Portugal
(State or country)

19 MAIDEN NAME OF MOTHER Gloria M. Sousa

20 BIRTHPLACE OF MOTHER (City) Portugal
(State or country)

21 Informant Mr. Albert C. Knox-friend
(Address) 27 Thornton St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Ralph E. Schumann
(Signature of Agent of Board of Health or other)

H. O. (Official Designation) 3/27/61 (Date of Issue of Permit)

R-301A

CERTIFICATE

DEATH

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27 1961

9-926662

(Registrar)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

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-926662

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop

(City or Town)

No. 41 Washington Ave., Bay View Nursing Home (If death occurred in a hospital or institution, St. (give its NAME instead of street and number))

Gertrude (Henderson) Nickerson

2 FULL NAME..... (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 52 Winthrop Street
(Usual place of abode)

Length of stay: In place of death 1 years 3 months days. In place of residence 50 years months days.

Registered No.

PHYSICIAN — IMPORTANT

((Was deceased a
U. S. War Veteran,
if so specify WAR)

58

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 2 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from 12/26 49 to 4/2 61
I last saw h. EL live on 1/31/61 19 death is said to have occurred on the date stated above, at 10:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY Occlusion

INTERVAL
BETWEEN
ONSET AND
DEATH
15 min(b) Due To ARTERIO-SCLEROSIS - GENERALIZED
ARTERIO-SCLEROTIC HEART DIS
HYPERTENSIVE HEART DIS

9 YRS

(c) Due To NEPHROSCLEROSIS.

2 YRS

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King M. D.

(PRINT OR TYPE SIGNATURE)
222 PLEASANT ST. WINTHROP 4/3 1961

(Address) Winthrop Winthrop

6 Place of Burial or Cremation Winthrop
DATE OF BURIAL April 5 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed APR 4 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widow

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Mortimer Nickerson

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 11 Months 16 Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 023-07-3987

16 BIRTHPLACE (City) Springhill
(State or country) Nova Scotia

17 NAME OF FATHER Unable to obtain

18 BIRTHPLACE OF FATHER (City) Unable to obtain H. I. King
(State or country)

19 MAIDEN NAME OF MOTHER Unable to obtain

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)21 Informant Mortimer Nickerson
(Address) 34 Thornberry Rd. Winchester

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

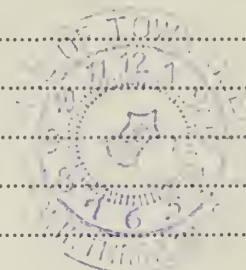
H.O. (Official Designation)

4/4/61 (Date of Issue of Permit)

MED. EXAM. CALLED & DECLINED JURISDICTION.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



RULES OF PRACTICE

APR - 4 1961 PM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

CERTIFICATE

DEATH

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-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 59

PLACE OF DEATH

SUFFOLK
(County)
WINTHROP
(City or Town)

No. WINTHROP COMMUNITY HOSP.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME DR. JACK M. KAYE
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence. No. 5415 Connecticut Ave N.W., WASH., D.C.
(Usual place of abode)
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....7.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 3 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
MAR. 31, 1961, to APRIL 3, 1961I last saw him live on APRIL 3, 1961, death is said to
have occurred on the date stated above, at 6:51 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION

INTERVAL
BETWEEN
ONSET AND
DEATH
8 MO.Due To (b) ARTERIOSCLEROTIC HEART
DISEASE

Due To (c)

OTHER SIGNIFICANT CONDITIONS CORONARY THROMBOSIS 8 MO

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) A. N. Caplan M.D.

(PRINT OR TYPE SIGNATURE) A. N. CAPLAN M.D.

(Address) 156 PRINCETON STREET, BROOKLYN, N.Y. 4-3-1961

6 UNION FIELD BROOKLYN, N.Y.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 4, 1961

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach
ADDRESS 10 Washington St., Dorchester

Received and filed APR 3 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Widower10a If married, widowed or divorced
HUSBAND of JEAN - Cannot be learned
(Give maiden name of wife in full)(or) WIFE of KATHERINE
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 64 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation DENTIST
(Kind of work done during most of working life)

14 Industry or Business Self-Employed

15 Social Security No.

16 BIRTHPLACE (City) BROOKLYN, N.Y.
(State or country)

17 NAME OF FATHER SAMUEL KAYE

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER BETTY ETTINGER

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)21 Informant ESTHER D. KAYE
(Address) 4808 Grantham St, Chevy Chase, Md.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sirriann
(Signature of Agent of Board of Health or other)40 atk APR 3 - 1961
(Official Designation) (Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

RECEIVED

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including results of septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS
 MEDICAL EXAMINER'S
 CERTIFICATE OF DEATH

To be filed for burial permit
 with Board of Health
 or its Agent.

Registered No.

60

Waters of Broad Sound

No.

(If death occurred in a hospital or institution,
 give its NAME instead of street and number)

2 FULL NAME

EDITH

D. (P.H.) WARNOCK

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
 U. S. War Veteran,
 if so specify WAR)

No

(a) Residence, No.

12 Seawall Ave.,

St.

Winthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 7.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

April

4,

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death
 of the person above-named and that the CAUSE AND MANNER thereof
 are as follows: (If an injury was involved, state fully.)

Asphyxia due to drowning.

5 Accident, suicide, or homicide (specify) Suicide.

Date and hour of injury19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
 Injury occur? Winthrop, Mass.

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
 public place? Waters off Winthrop, Mass.

(Specify type of place)

Manner of
 Injury Drowning.

(How did injury occur?)

Nature of
 Injury

While at work? Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.

Michael A. Luongo, M.D.

Boston (Print or Type Signature)

(Address) Date 4/5 1961

7 Central Cemetery

Place of Burial, or Cremation.

Dorchester

(City or Town)

DATE OF BURIAL

April

1961

8 NAME OF FUNERAL DIRECTOR

Eatonight Funeral Home

ADDRESS

419 No. Main St. Dorchester

Received and filed

APR 6 1961

19.....

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

Female

White

MARRIED

WIDOWED

or DIVORCED

Widowed

11a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

John Warnock

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE

57

Years

3

Months

27

Days

If under 24 hours

Hours

Minutes

14 Usual

Occupation:

Waitress

(Kind of work done during most of working life)

15 Industry

or Business:

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

Fennester

Vermont

18 NAME OF

FATHER

James Phillips

19 BIRTHPLACE OF

FATHER (City)

Scotland

(State or country)

20 MAIDEN NAME

OF MOTHER

Joan Simpson

21 BIRTHPLACE OF

MOTHER (City)

Scotland

(State or country)

22 Informant

(Address)

Mrs Annabelle Webber

1 Forest St Dorchester

I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scrimme
 (Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

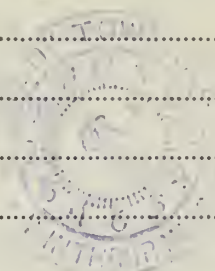
DATE OF ENTERING MILITARY SERVICE:

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 61

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 28 CHESTER AVENUE

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Carl

Lamm

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence, No.

28 Chester Ave

St.

WINTHROP

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 15 years.....months.....days. In place of residence 15 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

April

7

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw h..... alive on....., 19....., death is said to
have occurred on the date stated above, at 6:02 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

Natural Causes

Due To

(b)

Presumably Coronary Occlusion

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH

Was autopsy performed? no

What test confirmed diagnosis? Post Mortem Judgement

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Arthur C. Murray

M. D.

(Address)

Winthrop Board
of Health

Date 8 April 1961

6 MOUNT LEBANON, WEST ROXBURY
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 9

1961

7 NAME OF
FUNERAL DIRECTOR

ARNOLD GOLDB

ADDRESS

1668 BEACON ST. BROOKLINE

Received and filed

APR 11 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

MALE

WHITE

MARRIED

10a If married, widowed or divorced

HUSBAND of

SARAH STRAUSS

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

68

Years.....Months.....Days

If under 24 hours

.....Hours.....Minutes

13 Usual

Occupation: CHEMICAL MFG. CO.
(Kind of work done during most of working life)

14 Industry

or Business:

SELF EMPLOYED

15 Social Security No.

090-14-3983

16 BIRTHPLACE (City)

(State or country)

GERMANY

17 NAME OF
FATHER

JULIUS LAMM

18 BIRTHPLACE OF

FATHER (City)

GERMANY

(State or country)

19 MAIDEN NAME

OF MOTHER

SARAH (C.B.L.)

20 BIRTHPLACE OF

MOTHER (City)

GERMANY

(State or country)

21

Informant

(Address)

GEORGE LAMM

28 CHESTER AVE, WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simon

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

V.B.

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

250-101

APR 11 1961 AM

RULES OF PRACTICE

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-304



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

Registered No. 62

2 NAME OF FETUS
(if given)

Baby Girl Masiello

3 DATE OF DELIVERY APRIL 7 1961
Month Day Year4 SEX
Male ☒ Female ☐ Undetermined ☐

5 COLOR (if determined) W.

6 THIS BIRTH (Check one)
☒ Single ☐ Twin ☐ Triplet7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd

8 FULL NAME FATHER

DOMENIC NASIELLO

MOTHER

14 MAIDEN NAME ELIZABETH PAPA
PRESENT NAME ELIZABETH NASIELLO9 RESIDENCE, NO. 80 BAYS WATER STREET
CITY OR TOWN EAST BOSTON STATE MASS15 RESIDENCE, NO. 80 BAYS WATER STREET
CITY OR TOWN EAST BOSTON STATE MASS

10 COLOR OR RACE WHITE 11 AGE AT TIME OF THIS DELIVERY 36 (Years)

16 COLOR OR RACE WHITE 17 AGE AT TIME OF THIS DELIVERY 31 (Years)

12 PLACE OF BIRTH EAST BOSTON MASS
(City or Town) (State or country)18 PLACE OF BIRTH BOSTON MASS
(City or Town) (State or country)

13 OCCUPATION REFRIGERATION MECHANIC

19 INFORMANT DOMENIC NASIELLO

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

(a) How many children are now living? 3

(b) How many children were born alive but are now dead? One

(c) How many previous fetal deaths of ANY gestation age? 1

21 LENGTH OF PREGNANCY 22 completed weeks

22 WEIGHT OF FETUS
Lb. Oz. Grams23 WHEN DID FETUS DIE?
Before Labor ☒ During Labor ☐ or Delivery ☐ Unknown ☐24 AUTOPSY
Yes ☐ No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Unknown

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

none

26 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 10, 1961

27 NAME OF FUNERAL DIRECTOR DIPIETRO & VAZZA
ADDRESS 11 HENRY ST, EAST BOSTON

Received and filed

April 10, 1961

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 1st m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Charles Meloni

M.D.

CHARLES MELONI
(PRINT OR TYPE SIGNATURE)

Address 305 Haverhill St Date April 7, 1961

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni
Signature of Agent of Board of Health or other
H.O. 4/10/61

(Official Designation)

(Date of Issue of Permit)

RECEIVED

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No.

63

Suffolk
(County)Winthrop
(City or Town)No. Mount's Rest Home
141 Highland Ave.{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Richard Boland

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 2 Bayou Street

(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months..... days. In place of residence. 50 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 10, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
May 19, 1961, to April 10, 1961
I last saw him alive on April 8, 1961, death is said to
have occurred on the date stated above, at 6:00 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH
yo

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease
(b) arteriosclerosis - gen
(c) senilityOTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? -

What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed) Joseph D. Ward, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 194 Washington Ave 4/10/61

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 13, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass.

Received and filed APR 11 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED10a If married, widowed or divorced
HUSBAND of Helen Tierney
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: U.S. Postal employee

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Francis Boland

18 BIRTHPLACE OF

FATHER (City) Ireland
(State or country)19 MAIDEN NAME
OF MOTHER Mary McVey20 BIRTHPLACE OF
MOTHER (City) Ireland
(State or country)21 Informant Helen Boland
(Address) 2 Bayou St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Helen E. Tierney
Signature of Agent of Board of Health or other)H.O.
(Official Designation)April 11, 1961
(Date of Issue of Permit)

RECEIVED



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Revere

(City or Town making this return)

Suffolk

(County)

Revere

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 64

No. 340 Reservoir Ave.

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Thomas Fazio

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 194 Main
(Usual place of abode)

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence. 15 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 11, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 11, 1961, to April 11, 1961
I last saw him alive on April 11, 1961 death is said to
have occurred on the date stated above, at 12:15 P.m.INTERVAL
BETWEEN
ONSET AND
DEATH
2

hours

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute coronary thrombosis

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Coronary Thromb.

5yrs.
ago

Was autopsy performed? No

What test confirmed diagnosis? No

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No(Signed) D. D. Potito M. D.
17A Bennington St. 4/11 61
(Address) E. Boston Date6 Winthrop Winthrop
Place of Burial or Cremation April 15, 61
DATE OF BURIAL 197 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED Married
WIDOWED
or DIVORCED

10a If married, widowed or divorced

HUSBAND of Nicole De Blanca

(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 3

Years.....Months.....Days

If under 24 hours

.....Hours.....Minutes

13 Usual

Occupation:

Instructor

(Kind of work done during most of working life)

14 Industry
or Business:

Auto School

15 Social Security No.

033-160-6722

16 BIRTHPLACE (City)

(State or country)

Italy

17 NAME OF
FATHER

Thomas Fazio

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

Pietrina Galena

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

21

Informant
(Address)

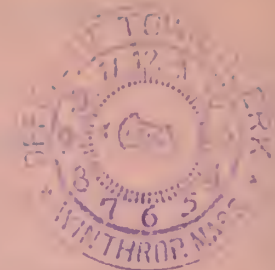
Mrs. Thomas Fazio

194 Main St., Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED April 14, 61



MAY 5 1961 PM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

PLACE OF DEATH

SUFFOLK

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME John Haugh

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 86 Bellevue Avenue

(Usual place of abode)

St. Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 11 days. In place of residence 35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 11 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
1-26-10 1961, to APRIL 11 1961I last saw him alive on APRIL 10 1961, death is said to
have occurred on the date stated above, at 2:44 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

INTERVAL
BETWEEN
ONSET AND
DEATH
7 mo.

Due To CARCINOMA OF LARYNX

(b)

5 YRS

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Myron H. King, M.D.

MYRON H. KING M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 22 - PLEASANT ST., Date 4/11 1961

Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 14, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Massachusetts

Received and filed APR 11 1961

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered

65

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed or divorced
HUSBAND of Catherine Tarmey
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Retired
Stationary Fireman
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 022 - 03 - 3788A

16 BIRTHPLACE (City Westport, Cty. Mayo
(State or country) Ireland)

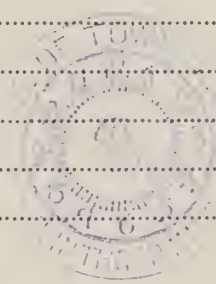
17 NAME OF FATHER Francis Haugh

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Burke, Mary

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Mary Haugh
(Address) 86 Bellevue Avenue, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Lynam
(Signature of Agent of Board of Health or other)H.O.
(Official Designation)April 11 - 1961
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —
THIS IS A PERMANENT RECORD

FORM R-302

1

PLACE OF DEATH

1

2 FULL NAME

(a) Residence, No.
(Usual place of abode)

Length of stay: In place of death, 8 years, 8 months, 6 days. In place of residence, years, months, days.

3 DATE OF
DEATH

MEDICAL CERTIFICATE OF DEATH

4 I HEREBY CERTIFY, That I attended deceased from
August 6, 1952 to April 12, 1961
I last saw him alive on April 12, 1961, death is said to
have occurred on the date stated above, at 9:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebro-Vascular Accident

Due To generalized Arteriosclerosis

Due To

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Andrew Nichols III, M.D.
Hathorne, Mass. 4/12/61
(Address) Date 19

6 Place of Burial or Cremation
Calvary Cemetery, Roslindale, Mass.
DATE OF BURIAL April 15, 1961

7 NAME OF
FUNERAL DIRECTOR Bernard S. McNamara
ADDRESS Boston, Mass.

Received and filed 19

(Registrar of City or Town where deceased resided)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 66

No. Danvers State Hospital, Hathorne

St. { If death occurred in a hospital or institution,
give its NAME instead of street and number)

George L. Manning

(If deceased is a married, widowed or divorced woman, give also maiden name.)

184 Somerset Avenue

// Winthrop, Mass.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX
male

9 COLOR
white

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED
single

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 10 Months 18 Days
If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Retired Government Inspector
(Kind of work done during most of working life)

14 Industry or Business: Unknown

15 Social Security No. South Boston

16 BIRTHPLACE (City) Mass.
(State or country)

17 NAME OF FATHER John Manning

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Feenan

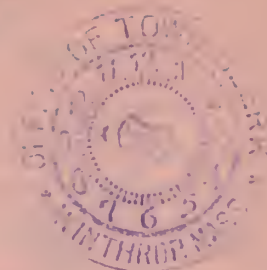
20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED April 17, 1961



MAY - 5 1961 PM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

INSTRUCTIONS
FOR
CERTIFICATEIn giving
OF DEATHdo not enter
more than one
cause for each
a), (b) and (c)s does not mean
mode of dying,
as heart failure,
etc. It means
disease, or compli-
s which causedditions, if any,
ch gave rise to
ve cause (a),
ing the under-
g cause last.ditions contrib-
to death but not
d to the terminal
condition givenChapter 137,
f 1954, requires
ians to print or
the cause or
of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

11 C

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No.

142 Pleasant St.

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)STANDARD
CERTIFICATE OF DEATH

Registered No.

2 FULL NAME Viola Marsters
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)

67

(a) Residence. No. 46 Washington Ave.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 12, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
FEB. 24, 1961, to APRIL 12, 1961.
I last saw him alive on APRIL 11, 1961, death is said to
have occurred on the date stated above, at 7:35 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHOPNEUMONIA

INTERVAL
BETWEEN
ONSET AND
DEATH

1 Wk

(b) MYOCARDIAL INFARCTION 3 MO

(c) ARTERIOSCLEROTIC HEART DISEASE 2 YRS

OTHER SIGNIFICANT CONDITIONS AMPUTATED LEFT LEG 3 MA
B. LATERAL BREAST ADENOMA

Was autopsy performed? No.

What test confirmed diagnosis? 2 CHICKEN LAB

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) M. TRAUNSTEIN, JR., M. D.
M. TRAUNSTEIN, JR.
(PRINT OR TYPE SIGNATURE)(Address) 73 BARTLETT ST. Date APRIL 2, 1961
Winthrop Winthrop Winthrop6 Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 14, 19617 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop MassReceived and filed APR 14 1961
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Single10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 8 Months 2 Days If under 24 hours
Hours Minutes13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 030-14-2534

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER George Marsters

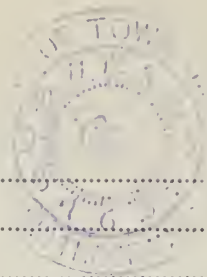
18 BIRTHPLACE OF FATHER (City) St. John
(State or country) New Brunswick

19 MAIDEN NAME OF MOTHER Mary Schlhuber

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.21 Informant Records O.A.A.
(Address) Town of WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING 4P2 1 41301 100
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

INSTRUCTIONS
FOR
VITAL CERTIFICATEIn giving
E OF DEATHnot enter
e than one
se for each
, (b) and (c)does not mean
ode of dying,
heart failure,
etc. It means
ase, or compli-
which causedtions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
der signature.

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)No. WINTHROP CONVALESCENT HOME
142 PLEASANT ST.2 FULL NAME CATHERINE G CAMPBELL (Daly)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 93 LOCUST ST.
(Usual place of abode)

Length of stay: In place of death..... 4 months..... days In place of residence. 40 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 15 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan 17 1961, to April 15 1961I last saw her alive on April 14 1961, death is said to
have occurred on the date stated above, at 6:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Arterio sclerosis general 20 yrs.

Was autopsy performed?

No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed)

Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, Mass. Date 4/15/1961

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 18 1961

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed 19

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No.

68

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED WIDOWED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of WILLIAM CAMPBELL
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years..... Months..... Days If under 24 hours
Hours..... Minutes13 Usual Occupation: HOUSE WIFE
(Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

17 NAME OF FATHER THOMAS DALY

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER ELIZABETH DIGMAN

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)21 Informant LOUISE MULLEN
(Address) 48 FOWLER ST REVEREI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

(Registrar)

0-59-925686

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

LPT 211961 R11

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

INSTRUCTIONS
FOR
VITAL CERTIFICATEn giving
E OF DEATHnot enter
e than one
se for each
, (b) and (c)does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which causedtions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
der signature.

0-659-925686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 69

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. Winthrop Convalescent Home St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME Charles Elmer Atwood (If deceased is a married, widowed or divorced woman give also maiden name)
PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, NO.
if so specify WAR)(a) Residence. No. 33 Bellevue Avenue St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 2 years months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 16 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
OCT 25 1952 to APRIL 16 1961
I last saw him alive on APRIL 16 1961 death is said to
have occurred on the date stated above, at 5:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCCLUSION
INTERVAL BETWEEN ONSET AND DEATH 15 MIN

Due To (b) ARTERIO-SCLEROTIC HEART DIS 5 YRS

Due To (c) GENERAL ARTERIO-SCLEROSIS 5 YRS

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 10 YRS

Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify(Signed) Myron N. King M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 222 Pleasant St. Date 4/18 19616 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 20 19617 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Katie Evelyn Gutterson
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 4 Months 28 Days
If under 24 hours
Hours Minutes13 Usual Occupation: retired messenger
(Kind of work done during most of working life)

14 Industry or Business: Railway Express Agency

15 Social Security No. none

16 BIRTHPLACE (City) Chester
(State or country) Vermont

17 NAME OF FATHER Alvin Atwood

18 BIRTHPLACE OF FATHER (City) Vermont
(State or country)

19 MAIDEN NAME OF MOTHER Brown

20 BIRTHPLACE OF MOTHER (City) Vermont
(State or country)21 Informant Loren Atwood
(Address) Tarzana, CaliforniaI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

R.O. 4/18/61
(Official Designation) (Date of Issue of Permit)

10

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death. Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)

No. Guardian Hospital

2 FULL NAME Anna Brandow (Gibson)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 10 Revere St.
(Usual place of abode)

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....7.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 17, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from April 11, 1961 to April 17, 1961
I last saw him live on April 17, 1961, death is said to have occurred on the date stated above, at 11:50PDEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Bronchopneumonia, TerminalDue To Massive Cerebrovascular
(b) AccidentDue To
(c)OTHER
SIGNIFICANT
CONDITIONSNo
Was autopsy performed? Exam
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Francis E. Smith
(Address) 85 Otis St. Camb. Apr. 18, 19616 Woodlawn Crematory Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 22, 19617 NAME OF FUNERAL DIRECTOR Howard S. Reynolds
ADDRESS Winthrop, Mass.

Received and filed 5-3-61 19

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Cambridge

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 563 70

(If death occurred in a hospital or institution, give its NAME instead of street and number)

(Was deceased a U. S. War Veteran, if so specify WAR.)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Widowed

10a If married, widowed, or divorced HUSBAND of John A. Brandow
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 0 Months 29 Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Kaptlight New York

17 NAME OF FATHER James T. Gibson

18 BIRTHPLACE OF FATHER (City) (State or country) Cannot be learned New York

19 MAIDEN NAME OF MOTHER Margaret Stranaghan

20 BIRTHPLACE OF MOTHER (City) (State or country) Cannot be learned New York

21 Informant (Address) Walter Johnson 10 Revere St. Winthrop

A TRUE COPY Frederick H. Burde

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED April 20, 1961



MAY 3 1961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 71

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 14 Waldemar Ave.,

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Curley

2 FULL NAME

Michael J. Kirley

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran,
if so specify WAR) WW #1

(a) Residence, No.

14 Waldemar Ave.

St.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 35.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

April 20, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from

1/27, 1958, to APRIL 20, 1961

I last saw him alive on APRIL 19, 1961, death is said to

have occurred on the date stated above, at 10:45 P.M.

INTERVAL
BETWEEN
ONSET AND
DEATH
6 mo.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

Due To

(b)

CARCINOMA OF STOMACH 8 MO

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

None.

Was autopsy performed? No.

What test confirmed diagnosis? OPERATION H.V.A. Hosp

5 Was disease or injury in any way related to occupation of deceased? No.

If so, specify

(Signed)

MYRON H. KING M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 122 PLEASANT ST. Date 4/21 1961

6 Holy Cross Cem. Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 24 1961

7 NAME OF
FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS

Winthrop Mass

Received and filed APR 24 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
or Divorced
Single

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 74 Years.....Months.....Days If under 24 hours

13 Usual
Occupation:

Retired Machinist

(Kind of work done during most of working life)

14 Industry
or Business:

Shipbuilding

15 Social Security No.

011-05-9475

16 BIRTHPLACE (City)

(State or country)

Ireland

17 NAME OF
FATHER

James Kirley

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER Maria C. Murray

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21

Informant

(Address)

Agnes Murphy

14 Waldemar Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

M R-301A

INSTRUCTIONS
FOR
CERTIFICATEn giving
OF DEATHnot enter
e than one
e for each
(b) and (c)does not mean
de of dying,
heart failure,
etc. It means
se, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ians to print or
the cause or
of death on
certificates, and
r 48, Acts of
requires Physi-
to print or type
under signature.

61-928145

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE..... 1-2-18

DATE OF DISCHARGE..... 9-30-21

RANK, RATING..... A.M.M 1st C1

ORGANIZATION AND OUTFIT..... U.S. Navy

SERVICE NUMBER..... 1235160

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

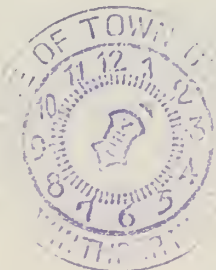
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



APR 24 1901

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-6-60-9281J5

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S

CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 72

No. 4 Elmwood Court, Winthrop

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

2 FULL NAME CAROL ANN MARGOTTA

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a

U. S. War Veteran,

if so specify WAR)

(a) Residence. No. 4 Elmwood Court, Winthrop

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

PNEUMONITIS

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

(Specify type of place)

Manner of

Injury

(How did injury occur?)

While at work? Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Leonard Atkins, M.D.

Leonard Atkins, M.D.

(Print or Type Signature)

Boston

4/20

61

(Address)

Date

19

7 Winthrop

Winthrop

Place of Burial, or Cremation.

(City or Town)

DATE OF BURIAL April 21

19

8 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St, Winthrop

Received and filed

19

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

Female

White

MARRIED
WIDOWED
or DIVORCED

Single

11a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE

Years

2

Months

Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

(Kind of work done during most of working life)

15 Industry

or Business:

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

Winthrop

Mass

18 NAME OF

FATHER

James F Margotta

19 BIRTHPLACE OF

FATHER (City)

Stamford

(State or country)

Conn.

20 MAIDEN NAME

OF MOTHER

Sheila Haraden

21 BIRTHPLACE OF

MOTHER (City)

Portland

(State or country)

Me.

22

Informant

(Address)

James F Margotta

4 Elmwood Ct, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Surinini

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

X

VED SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
1951 AM
1951 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"



The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit with
Board of Health or its Agent.

CERTIFICATE OF FETAL DEATH
(STILLBIRTH)

Registered No. 73

PLACE OF DELIVERY

Suffolk
(County)
Wintthrop
(City or Town)

No. Wintthrop Community Hospital

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 NAME OF FETUS
(if given)

Baby Boy Gillis

3 DATE OF DELIVERY April 29, 1961
(Month) (Day) (Year)

4 SEX

Male ☒ Female ☐ Undetermined ☐

5 COLOR (if
determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin ☐ Triplet ☐

7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd

FATHER

8 FULL
NAME

Walter Gillis

9 RESIDENCE, NO.
CITY OR TOWN

129 Cottage St.
East Boston

STREET
STATE Mass.

10 COLOR OR
RACE

W

11 AGE AT TIME OF
THIS DELIVERY 43 (Years)

12 PLACE OF
BIRTH

Wintthrop, Mass.
(City or Town)

State or country

13

OCCUPATION

Packer

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

3

(a) How many children are
now living?

2

(b) How many children were
born alive but are now
dead?

0

(c) How many previous fetal
deaths of ANY gestation
age?

1

21 LENGTH OF
PREGNANCY

38 completed weeks

22 WEIGHT OF FETUS
Lb. Oz
(or Grams)

23 WHEN DID FETUS DIE?
Before Labor ☒ During Labor ☐ Unknown ☐

24 AUTOPSY

Yes

No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

Unknown

Due To (b)

? Diabetes

Due To (c)

OTHER SIGNIFICANT
CONDITIONS

Macerated Fetus

26

Place of Burial or Cremation
DATE OF BURIAL

Holy Cross Cemetery

Malden

(City or Town)

May 2,

1961

27 NAME OF
FUNERAL DIRECTOR
ADDRESS

Vincent Rapino

9 Chelsea St., East Boston, Mass.

Received and filed

MAY 2 1961

19

Registrar

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 5:25 pm. and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Louis E. Schwafta

M.D.

Louis E. Schwafta
(PRINT OR TYPE SIGNATURE)

Address 15 Bennington St.
East Boston

Date April 29, 1961

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial, or transit permit was issued

Signature of Agent of Board of Health or other)

Official Designation

(Date of Issue of Permit)

In giving
CAUSE OF
FETAL DEATH
do not enter
more than one
cause for each
of (a), (b)
and (c)

tal or maternal
condition causing
fetal death (do
not use such
terms as stillbirth
or prematurity.)
fetal and/or ma-
ternal conditions,
any, which gave
rise to above
cause (a), stating
the underlying
cause last.

Conditions of fetus
or mother which
may have contrib-
uted to fetal
death, but, in so
far as is known,
are not related
to cause given
in (a).

Signature of Agent of Board of Health or other)

40 May 2/1961

FETAL DEATH



EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

MAY 7 1961 AM

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

In giving
STATE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
etc. It means
disease, or compli-
cations which caused

ditions, if any,
which gave rise to
the cause (a),
being the under-
lying cause last.

conditions contrib-
uted to death but not
fatal to the terminal
condition given

Chapter 137,
of 1954, requires
physicians to print or
type the cause or
causes of death on
certificates, and
under 48, Acts of
1959 requires Physi-
cians to print or type
under signature.

PLACE OF DEATH

1

Suffolk

(County)

Winthrop, Mass.

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME McGuirk, Twin Girl #1

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 8 Constitution Ave. Revere, Mass.

(Usual place of abode)

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 26, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from

4/26/61 to 4/26/61

I last saw him alive on 4/26/61, death is said to

have occurred on the date stated above, at 3:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity

Due To Premature labor

Due To Placenta Previa marginal

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) A. Paul DAKHAGOPIAN, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 39 CLARY AVE WALSLEY, Mass. Date 4/26/61

6 Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 28, 1961

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS 45 Alderman Ave. E. Boston

Received and filed APR 28 1961

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 74

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word MARRIED, WIDOWED or DIVORCED) Single

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years.....Months.....Days 12 Hours 5 Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Winthrop, Mass. (State or country)

17 NAME OF FATHER James McGuirk

18 BIRTHPLACE OF FATHER (City) Revere, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Eleanor Lane

20 BIRTHPLACE OF MOTHER Winthrop, Mass. (State or country)

21 Informant James McGuirk (Address) 8 Constitution Ave. Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

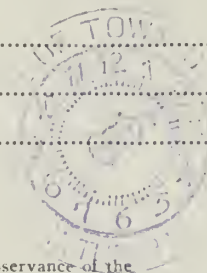
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

IN GIVING
STATE OF DEATH

Do not enter
more than one
cause for each
(a), (b) and (c)

Does not mean
mode of dying,
as heart failure,
jaundice, etc. It means
cause, or compli-
cations, which caused

Conditions, if any,
which gave rise to
the cause (a),
including the under-
lying cause last.

Conditions contrib-
uting to death but not
leading to the terminal
condition given

Chapter 137,
1954, requires
physicians to print or
write the cause or
mode of death on
certificates, and
Chapter 48, Acts of
1954, requires Physi-
cians to print or type
their signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 75

PLACE OF DEATH

WINTHROP
(City or Town)

No. Winthrop Community Hospital

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME CHRISTINE (Cleary) MAHONEY
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 73 Green Street St. Charlestown
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 2 days. In place of residence 22 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 27 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 25, 1961 to April 27, 1961
I last saw her alive on April 26, 1961, death is said to
have occurred on the date stated above, at 2:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

Due To (b) Cerebral Arteriosclerosis

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
Charles Liberman
(PRINT OR TYPE SIGNATURE)
(Address) Winthrop Mass Date 4/27/1961

6 ST JOSEPH'S W. ROXBURY
Place of Burial or Cremation (City or Town)
DATE OF BURIAL MAY 1 1961

7 NAME OF FUNERAL DIRECTOR Frank Carr
ADDRESS CHARLESTOWN

Received and filed APR 27 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED WIDOW

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of JAMES JOSEPH MAHONEY
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: HOUSE-WORK wife
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) NEWFOUNDLAND
(State or country) CANADA

17 NAME OF FATHER PETER CLEARY

18 BIRTHPLACE OF FATHER (City) NEWFOUNDLAND
(State or country) CANADA

19 MAIDEN NAME OF MOTHER MARY O'BRIEN

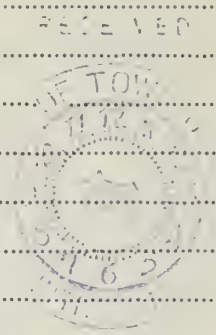
20 BIRTHPLACE OF MOTHER (City) NEWFOUNDLAND
(State or country) CANADA

21 Informant MRS CHRISTINE CORBETT
(Address) 56 GREEN ST CHARLESTOWN

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit-permit was issued:

Signature of Agent of Board of Health or other
140 att April 27 - 1961
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



—————
 RULES OF PRACTICE 4P. 271501 m

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

—————
Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

—————
Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

IN GIVING
OF DEATH

to not enter
more than one
cause for each
(a), (b) and (c)

does not mean
code of dying,
his heart failure,
etc. It means
cause, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
ing the under-
cause last.

conditions contrib-
to death but not
to the terminal
condition given

Chapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
r 48, Acts of
quires Physi-
to print or type
nder signature.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 23 Tewksbury Street

2 FULL NAME

Emil Krauthausen

(If deceased is a married, widowed or divorced woman, give also maiden name.)

23 Tewksbury Street

(a) Residence. No.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 45 years.....months.....days. In place of residence 45 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

April 29 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....

I last saw h.....alive on 19....., death is said to
have occurred on the date stated above, at 10:05 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To

(b) Presumably Coronary Occlusion

Due To

(c) Arteriosclerotic Heart Disease

OTHER

SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Arthur C. Murray M. D.

Arthur C. Murray

(PRINT OR TYPE SIGNATURE)

Winthrop Board of Health May 1961

Woodlawn Crematory

Everett

Place of Burial or Cremation

May 3

(City or Town)

DATE OF BURIAL

19 61

7 NAME OF

FUNERAL DIRECTOR

Howard S Reynolds

ADDRESS

Winthrop Mass

Received and filed

MAY 2 1961

19.....

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Registered No.

76

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED Married
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Elise Weise

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 88 Years 10 Months 4 Days

If under 24 hours

.....Hours.....Minutes

13 Usual

Occupation:

Waiter

(Kind of work done during most of working life)

14 Industry

or Business:

Hotel

15 Social Security No.

030-03-6634

16 BIRTHPLACE (City)

(State or country)

Berlin
Germany

17 NAME OF

FATHER

Unable to obtain

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Unable to obtain

19 MAIDEN NAME

OF MOTHER

Unable to obtain

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Unable to obtain

21

Informant

(Address)

Elise Krauthausen

23 Tewksbury St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Newman

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

may 2 - 1961
H.O. at
LBK

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



MAY 2 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 77

Suffolk
(County)
Winthrop
(City or Town)

No. 12 Charles St

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frank G. Corbitt
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
(if so specify WAR) No

(a) Residence, No. 12 Charles St
(Usual place of abode) St.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 1, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
May 29, 1950, to May 1, 1961
I last saw him alive on May 1, 1961, death is said to
have occurred on the date stated above, at 9:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

INTERVAL
BETWEEN
ONSET AND
DEATH
45 min

Due To (b) Arteriosclerotic heart disease 2 yrs

Due To (c) Generalized arteriosclerosis 4 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Date 5, 2 1961

6 Cremation
Woodlawn Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 4, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed MAY 4 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married

10a If married, wife's name Hennessey
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: Music Business

15 Social Security No. 021-07-2682

16 BIRTHPLACE (City) Jeffersonville
(State or country) Ohio

17 NAME OF FATHER Oliver K. Corbitt

18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country)

19 MAIDEN NAME OF MOTHER Anna Marie Gillespie

20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country)

21 Informant Maetruue Corbitt
(Address) 12 Charles St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
(b) and (c)

does not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

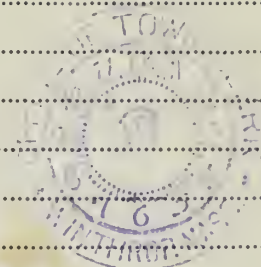
ons, if any,
have rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
condition given

- Chapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
requires Physi-
print or type
under signature.

928145

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



MAY - 4 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 78

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 30 James Ave.

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME George W Coffin
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 30 James Ave
(Usual place of abode) 63

St. 91
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 2 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
2-10-1961, to 5-1-61, 19
I last saw him live on May 1, 1961, death is said to
have occurred on the date stated above, at 9:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Heart
disease

Due To (b) Arteriosclerotic
Heart disease

Due To (c) Chronic Myocarditis

INTERVAL
BETWEEN
ONSET AND
DEATH

3 yrs

3 yrs

3 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph J. Zambella, M. D.

(Address) 30 James Ave, Winthrop 5/2/61

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 4 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass

Received and filed MAY 3 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married

10a If married, widowed, or divorced, Minnie C Boyd
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 92 Years 8 Months 4 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Carpenter Builder (retired)
(Kind of work done during most of working life)

14 Industry or Business: Self

15 Social Security No. None

16 BIRTHPLACE (City) Mt Stewart
(State or country) Prince Edward Island

17 NAME OF FATHER Duncan Coffin

18 BIRTHPLACE OF FATHER (City) Prince Edward Island
(State or country)

19 MAIDEN NAME OF MOTHER Jessie Scott

20 BIRTHPLACE OF MOTHER (City) Prince Edward Island
(State or country)

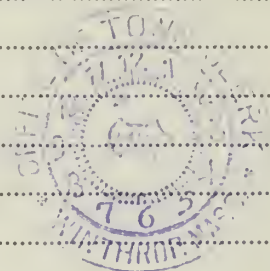
21 Informant Minnie C Coffin
(Address) 30 James Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lerman
(Signature of Agent of Board of Health or other)

H. O. (Official Designation) May 3 1961 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



MAY 3 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

not enter
than one
for each
(b) and (c)

es not mean
of dying,
heart failure,
etc. It means
the under-
cause last.

ns, if any,
ve rise to
ause (a),
the under-
ause last.

ions contrib-
eath but not
the terminal
dition given

Chapter 137,
1954, requires
ns to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
der signature.

PLACE OF DEATH

Suffolk
Winthrop
(City or Town)

No. *Winthrop Comm. Hosp.*

2 FULL NAME *Mary Cataldo*

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. *122 Broadway* St. *Revere, Mass.*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *MAY 5 61*
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from *SEPT 5*, 19*60*, to *MAY 5*, 19*61*.

I last saw her alive on *MAY 5*, 19*61*, death is said to have occurred on the date stated above, at *6:33 P.m.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *LEFT VENTRICULAR DILATATION*

Due To (b) *AORTIC STENOSIS AND REGURG.*

Due To (c) *RHEUMATIC HEART DISEASE*

OTHER SIGNIFICANT CONDITIONS *ANTERO-POSTERIOR MYOCARDIAL INFARCTION*

Was autopsy performed? *N*

What test confirmed diagnosis? *E.C.G.*

5 Was disease or injury in any way related to occupation of deceased? *No*

If so, specify

(Signed) *Charles J. Cataldo*, M. D.
CHARLES J. CATALDO
(PRINT OR TYPE SIGNATURE)

(Address) *48 B. P. COIN ST. F.B.S.T. Date: MAY 6 19 61*

6 *Holy Cross Cem. Malden*
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *May 8, 19 61*

7 NAME OF FUNERAL DIRECTOR *Paul Buonfiglio*

ADDRESS *128 Revere St Revere*

Received and filed *MAY 8 1961*

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Registered No. *79*

{(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran, if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *Female* 9 COLOR *White* 10 SINGLE (write the word) *Widowed*

10a If married, widowed, or divorced HUSBAND of *Amorino Cataldo* (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE *61* Years *1* Months *—* Days If under 24 hours Hours Minutes

13 Usual Occupation: *Housewife* (Kind of work done during most of working life)

14 Industry or Business: *at Home*

15 Social Security No.

16 BIRTHPLACE (City) *Italy* (State or country)

17 NAME OF FATHER *Edward Columbo*

18 BIRTHPLACE OF FATHER (City) *Italy* (State or country)

19 MAIDEN NAME OF MOTHER *Cannot Be Learned*

20 BIRTHPLACE OF MOTHER (City) *Italy* (State or country)

21 Informant *Mrs. Mary Cella* (Address) *36 Ambrose St Revere*

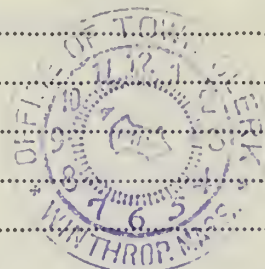
I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Liberman
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) *May 7, 1961*

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



MAY 8 1961 MM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

med. cert.
Examiners

M R-301A

INSTRUCTIONS
FOR
L CERTIFICATE

a giving
OF DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

- Chapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
under signature.

-659-925686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 80

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



No. West Haven Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Zigman (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 49 Warren Ave St. Chelsea
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years — months — days. In place of residence 53 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 9 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Nov. 1959 to May 9 1961

I last saw him alive on May 1 1961, death is said to have occurred on the date stated above, at 8:05 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary heart disease 54 yrs.

Due To (b) Arteriosclerosis

Due To (c) Pulmonary Emphysema

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? E.C.G.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Abraham Gold, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 100 Washington Ave Chelsea Date May 9 1961

6 Liberty Progressive EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 10 1961

7 NAME OF FUNERAL DIRECTOR ICRF Funeral Service Inc
ADDRESS 151 Washington Ave Chelsea

Received and filed MAY 10 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED
WIDOWED Divorced or DIVORCED

10a If married, widowed, or divorced Kala Shapiro
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years — Months — Days If under 24 hours — Hours — Minutes

13 Usual Occupation: Building Contractor
(Kind of work done during most of working life)

14 Industry or Business: Building Trade

15 Social Security No. 022-16-7468

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Barney Zigman

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Lifoha (CBL)

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Lillian Mendelsohn
(Address) 9 Strathmore Rd Brookline

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seligman
(Signature of Agent of Board of Health or other)

H.O. May 10 - 1961
(Official Designation) (Date of Issue of Permit)

X

William Zigman

022-16-746

Social Security

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF F

The fulfillment of the purpose of these following rules of practice:

(1) **Attending physicians** will certify to persons to whom they have given bedside care during related to any form of injury.

(2) **Board of Health physicians** will certify to such persons who, though disabled by recognized disease unrelated to injury, have died without recent medical attendance or whose absence from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposed to be due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-59-926111

1

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 81

No. Danvers State Hospital, Hathorne. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eva Fronduto (Fortin) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, No)

(a) Residence, No. 60 Pebble Avenue Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, 4 months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 17, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 17, 1961 to May 17, 1961 I last saw her live on May 17, 1961 death is said to have occurred on the date stated above, at 5:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Uterus with metastases

INTERVAL
BETWEEN
ONSET AND
DEATH

months

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Decubitus of back

Was autopsy performed? no What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Andrew Nichols III M. D.

(Address) Hathorne, Mass. Date 5-17-1961

6 Holy Cross Cemetery, Malden Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 20, 1961

7 NAME OF FUNERAL DIRECTOR Vincent Rapino E. Boston, Mass.

ADDRESS JUN 8 1961

Received and filed 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED married

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Nicholas Fronduto (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 55 Years 10 Months 17 Days If under 24 hours Hours Minutes

13 Usual Occupation housewife (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 030-16-1177

16 BIRTHPLACE (City) Quebec (State or country) Canada

17 NAME OF FATHER Seraphin Fortin

18 BIRTHPLACE OF FATHER (City) Unknown (State or country) Canada

19 MAIDEN NAME OF MOTHER Virginia, maiden name

20 BIRTHPLACE OF MOTHER (City) Unknown (State or country) Canada

21 Informant Mary E. Sheehan (Address) Hathorne, Mass.

A TRUE COPY

ATTEST: Daniel J. Toomey (Registrar of City or Town where death occurred)

DATE FILED May 24, 1961

JUN - 61961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

INSTRUCTIONS
FOR
VITAL CERTIFICATEn giving
OF DEATHnot enter
e than one
se for each
, (b) and (c)does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which causedtions, if any,
gave rise to
cause (a),
g the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
ne cause or
of death on
artificates, and
48, Acts of
quires Physi-
print or type
der signature.

PLACE OF DEATH

SUFFOLK

(County)

Winthrop, Mass.

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Michael Zichello

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 237 Everett, 3t.

(Usual place of abode)

St. East Boston, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....2.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 17 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Jan 5, 1961, to May 17, 1961.
I last saw him alive on May 16, 1961, death is said to
have occurred on the date stated above, at 9:54 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

Due To (b) Carcinoma of lip
and neck

Due To (c)

OTHER SIGNIFICANT CONDITIONS arteriosclerosis
generalized

Was autopsy performed?

What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed) Joseph Gregorie, M. D.

(PRINT OR TYPE SIGNATURE) JOSEPH GREGORIE

(Address) 194 Broadway, Boston, Mass. Date 5-17 1961

6 St. Michael Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 20, 1961

7 NAME OF FUNERAL DIRECTOR Vincent Rapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed MAY 17 1961

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 82

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, NO
if so specify WAR)

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married10a If married, widowed, or divorced Vincenza Stampone
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Retired
(Kind of work done during most of working life)

14 Industry or Business *****

15 Social Security No. 010-14-2230

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Nicola Zichello

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Maria Rosa Mariano

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Vincenza Zichello (wife)
(Address) 237 Everett St., East BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Merriam
(Signature of Agent of Board of Health or other)H. O. May 17 - 1961
(Official Designation) (Date of Issue of Permit)

(Registrar)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

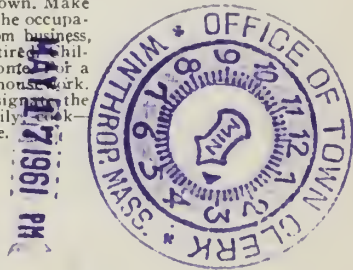
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home, or a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family—hotel, etc. For a person who had no occupation whatever write none.



RECEIVED

INSTRUCTIONS
FOR
VITAL CERTIFICATEIn giving
OF DEATHnot enter
than one
se for each
, (b) and (c)does not mean
ode of dying,
heart failure,
, etc. It means
ease, or compli-
which causeditions, if any,
gave rise to
cause (a),
g the under-
cause last.ditions contrib-
o death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
der signature.

PLACE OF DEATH

SUFFOLK

(County)

Winthrop, Mass.

(City or Town)

No. Winthrop Community Hospital



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 81

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Richard Petroccione
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence. No. 377 Frankfort St. East Boston, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....15 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 18, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
5/3 1961, to MAY 18 1961
I last saw him live on 5/18 1961, death is said to
have occurred on the date stated above, at 10:43AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Oppenheimer Disease

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no.

What test confirmed diagnosis?
5 Was disease or injury in any way related to occupation of deceased? no.
If so, specify

(Signed) D. D. Potito M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 17A Penn St. B. 5/18 1961

6 ST. MICHAEL CEM. BOSTON

Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 19 1961

7 NAME OF FUNERAL DIRECTOR PENNACCHIO & SON

ADDRESS 59 So. MARGIN ST. BOSTON

Received and filed MAY 18 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED single10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE.....Years.....6 Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

17 NAME OF FATHER Joseph Petroccione

18 BIRTHPLACE OF FATHER (City) East Boston, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Mary Rodrigues

20 BIRTHPLACE OF MOTHER (City) East Boston, Mass.
(State or country)21 Informant Jos. PETROCCIONE
(Address) 377 FRANKFORT ST., E.B.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) May 18, 1961

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



MAY 18 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 81

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Amelia Iannone (Gennaro)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, if so specify WAR) noINSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

(a) Residence. No. 19 Wheelock

St. Winthrop

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. 1 In place of residence. 14 years.....months.....days.

n giving
E OF DEATHnot enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
heart failure,
etc. It means
ase, or compli-
which causedtions, if any,
gave rise to
cause (a),
g the under-
cause last.ditions contrib-
o death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
the cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
der signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 22 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
FEB 1960 to MAY 22 1961I last saw her live on MAY 21 1961, death is said to
have occurred on the date stated above, at 3:50 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH

3 MO.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS
WITH JAUNDICE

Due To CARCINOMA OF BREAST

15 MO.

(b)

OTHER
SIGNIFICANT CONDITIONS NONE

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL + OPERATION

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Myron N. King M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 222 PLEASANT ST. Date 5/22 1961

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 25, 1961

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAY 23 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED or DIVORCED married

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Domenic Iannone
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 16 Months 16 Days
If under 24 hours Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) Italy
(State or country)

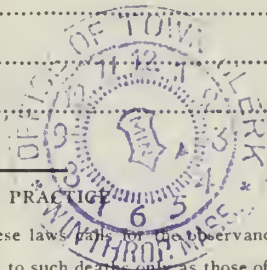
17 NAME OF FATHER Rocco Gennaro

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Secondina ?

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Domenic Iannone
(Address) 19 Wheelock St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Schumann
(Signature of Agent of Board of Health or other)H.O. May 23-1961
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws rests for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease, had not been attended to by any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
use, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

Chapter 137,
1954, requires
ns to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 85

No. Winthrop Com. Hosp St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME EVA MINSK (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 30 Circuit Rd St. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 7 years months days.

MEDICAL CERTIFICATE OF DEATH PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH MAY 22, 1961 (Month) (Day) (Year)

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Widowed or DIVORCED

4 I HEREBY CERTIFY That I attended deceased from Dec 1947 to May 22, 1961

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

I last saw her alive on May 22, 1961, death is said to have occurred on the date stated above, at 1:00 A.M.

(or) WIFE of Max MINSK (Husband's name in full)

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

11 IF STILLBORN, enter that fact here.

(a) Arteriosclerotic Heart Disease

12 AGE 73 Years Months Days If under 24 hours Hours Minutes

Due To (b) Cardiac Decompensation 3 mos.

13 Usual Occupation: Housewife (Kind of work done during most of working life)

Due To (c) Thrombocytopenic Purpura 4 yrs.

14 Industry or Business: At Home 15 Social Security No. None

OTHER SIGNIFICANT CONDITIONS Thrombocytopenic Purpura

16 BIRTHPLACE (City) (State or country) Roumania

Was autopsy performed? No What test confirmed diagnosis? Clinical

17 NAME OF FATHER Hyman Rosenberg

5 Was disease or injury in any way related to occupation of deceased No If so, specify

18 BIRTHPLACE OF FATHER (City) (State or country) Roumania

(Signed) Charles Liberman M.D. CHARLES LIBERMAN (PRINT OR TYPE SIGNATURE)

19 MAIDEN NAME OF MOTHER CBL

(Address) Winthrop Mass Date 5/22/61

20 BIRTHPLACE OF MOTHER (City) (State or country) Roumania

6 Place of Burial or Cremation Liberty Progressive Cemetery (City or Town) DATE OF BURIAL May 23 1961

21 Informant (Address) Betty Lewis 30 Circuit Rd Winthrop

7 NAME OF FUNERAL DIRECTOR TAFE Funeral Service ADDRESS 151 Washington Ave Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: (Signature of Agent of Board of Health or other)

Received and filed MAY 23 1961

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

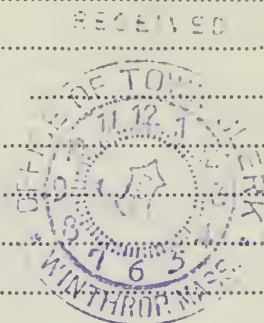
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



RULES OF PRACTICE

MAY 23 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 86

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 26 WAVE WAY AVE

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME

Lena (Peckerman) Diamond

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 26 WAVE WAY AVE

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 3 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 27 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19..... to 19.....

I last saw him alive on 19....., death is said to
have occurred on the date stated above, at 7 A. m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To (b) Presumably Coronary Occlusion

Due To (c) Anteriosclerotic Heart Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? post mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray, M. D.

ARTHUR C. MURRAY (PRINT OR TYPE SIGNATURE)

(Address) Winthrop Board of Health May 19 61

6 EMERALD ST SHUL CEM. WOBURN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 28 19 61

7 NAME OF FUNERAL DIRECTOR MURRAY GOLDMAN

ADDRESS 174 FERRY ST MALDEN

Received and filed MAY 29 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED MARRIED WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of MORRIS DIAMOND
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No.

16 BIRTHPLACE (City) ROMANOW
(State or country) RUSSIA

17 NAME OF FATHER JOSEPH PECKERMAN

18 BIRTHPLACE OF FATHER (City) UNKNOWN
(State or country) RUSSIA

19 MAIDEN NAME OF MOTHER ZISEL (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) (UNKNOWN)
(State or country) RUSSIA

21 Informant MARY BLOCK
(Address) 26 WAVE WAY AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 5/27/61

R-301A

CTIONS
FOR
CERTIFICATE

giving
OF DEATH

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for each
b) and (c)

es not mean
of dying,
heart failure,
etc. It means
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which caused

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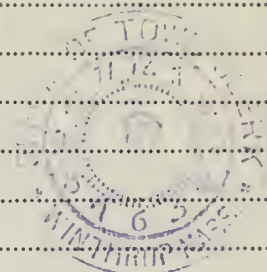
tions contrib-
death but not
the terminal
condition given

Chapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

928145

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



MAY 29 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-2-58-922072

PLACE OF DEATH

Middlesex
(County)
Waltham
(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Waltham
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. **243 82**

No. **Walter E. Fernald State School** St. (If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME **Charles Francis Hamburger**
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Residence. No. **cannot be learned** St. **Winthrop, Mass.**
(Usual place of abode) (If nonresident, give city or town and State)
Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **May 28, 1961**
(Month) (Day) (Year)
4 I HEREBY CERTIFY, That I attended deceased from **May 1, 1960** to **May 28, 1961**
I last saw him on **May 26, 1961**, death is said to have occurred on the date stated above, at **6:00am** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) **Coma due to cirrhosis of the liver**

Due To **Bronchial pneumonia of right lung.**
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? **yes**
What test confirmed diagnosis? **autopsy**

5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify

(Signed) **Silvio Margulis**
Waverley, Mass. 5-29 M. 81
(Address) **Met Fern cem., Waltham** Date **19**

6 Place of Burial or Cremation **June 2** (City or Town) **61**
DATE OF BURIAL **June 2** 19**61**

7 NAME OF FUNERAL DIRECTOR **Lee M. Fraser**
Waltham, Mass.
ADDRESS

Received and filed **JUN 9 1961** 19**61**

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** **9 COLOR** **white** **10 SINGLE** (write the word)
MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) **WIFE of** (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **61** Years **8** Months **23** Days
If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: **None**
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. **Onset**

16 BIRTHPLACE (City) **Mass.**
(State or country)

17 NAME OF FATHER **Charles M. Hamburger**

18 BIRTHPLACE OF FATHER (City) **Boston**
(State or country) **Mass.**

19 MAIDEN NAME OF MOTHER **Mina A. Loveren**

20 BIRTHPLACE OF MOTHER (City) **Wadford**
(State or country) **Mass.**

21 Informant **WEP School**
(Address) **Waltham, Mass.**

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED **June 2** 19**61**

RECEIVED



JUN - 9 1961 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town in which the death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Suffolk

(County)

Revere

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

COPY OF

CERTIFICATE OF DEATH

Revere

(City or Town making this return)

Registered No. 88

No. Grover Manor Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph A. Recomendendes (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 436 Pleasant St. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years 7 months 7 days. In place of residence 20 years 7 months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 29, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY. That I attended deceased from May 23 61 to May 29 61 in May 29 61 I last saw him on May 29 61 death is said to have occurred on the date stated above, at 2:30P.

INTERVAL BETWEEN ONSET AND DEATH 12 hours

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Thrombosis

Due To (b) Paroxysmal Auricular Tachycardia

10 days

Due To (c)

OTHER SIGNIFICANT CONDITIONS Cirrhosis of liver

8 yrs.

Was autopsy performed? No Clinical What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) Joseph J. Palermo M. D. 20 Crescent Ave. 5/29 61 (Address) Revere Date 5/29 61

6 Winthrop Cemetery Winthrop Place of Burial or Cremation (City or Town) June 1, 61 DATE OF BURIAL 19

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley ADDRESS Winthrop

Received and filed JUN 5 1961 (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED or DIVORCED

10a If married, widowed, or divorced HUSBAND of Lillian M. Krovitz (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 Years 61 Months 61 Days If under 24 hours 61 Hours 61 Minutes

13 Usual Occupation: Retired Salesman (Kind of work done during most of working life)

14 Industry or Business: Fish

15 Social Security No. Boston

16 BIRTHPLACE (City) Mass. (State or country)

17 NAME OF FATHER Joseph Recomendendes

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Annie E. Connelley

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Lillian M. Recomendendes (Address) 436 Pleasant St., Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED May 31, 1961



JUN 5 1961 AM

Married

White

Male

William M. Smith

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE May 22, 1918

DATE OF DISCHARGE Sept. 30, 1921

RANK, RATING Yeoman 3 Cl. Prov.

ORGANIZATION AND OUTFIT U S N R F

SERVICE NUMBER 182 62 06

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent

STANDARD
CERTIFICATE OF DEATH

Registered No.

02113

Suffolk
(County)

Boston
(City or Town)

No. New England Deaconess Hospital

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Anna M. Frongello (nee Battaglia)

(First Name)

(Middle Name)

(Last Name)

{(Was deceased a
U. S. War Veteran, NO
if so specify WAR)}

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 153 Locust St.
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay. In place of death years months 10 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 28 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
February 18, 1961 to Feb. 28, 1961

I last saw her alive on February 27, 1961, death is said to
have occurred on the date stated above, at 6:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Myocardial infarction

(a) Arteriosclerotic heart disease

(b) Chronic nephritis

OTHER SIGNIFICANT
CONDITIONS Diabetes
Obesity

INTERVAL
BETWEEN
ONSET AND
DEATH
10+ DAYS
10+
YEARS
10+
YEARS
15+ YRS
30+ YRS

Was autopsy performed? No

What test confirmed diagnosis? Physical examination &
Laboratory data

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Allen P. Joslin, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 15 Joslin Rd., Boston, Mass. Date Feb. 28, 1961

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 3, 1961

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed MAR 3 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)

MARRIED

WIDOWED Married

or DIVORCED

10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Gaetano Frongello
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE

64

Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

Houswife

(Kind of work done during most of working life)

14 Industry
or Business:

At home

15 Social Security No.

unknown

16 BIRTHPLACE (City)
(State or country)

New York

17 NAME OF
FATHER

Louis Battaglia

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

Concetta Presutti

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

21

Informant Gaetano Frongello (husband)

(Address) 153 Locust St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me before the burial or cremation permit was issued.

(Signature of Agent of Board of Health or other)

A15373
(Official Designation)

Mar 1, 1961
(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

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54, requires
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ificates, and
48, Acts of
quires Physi-
print or type
er signature.

14 1961

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)

No.

Veterans Administration Hospital

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME

ELMONS, K. BERRY

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{ (Was deceased a
U. S. War Veteran,
if so specify WAR)

W.I.

(a) Residence, No.

19 George

(Usual place of abode)

St.

Winthrop, Mass.

(If non-resident, give city or town and State)

Length of stay: In place of death years 1 months 20 days. In place of residence. 64 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 1 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That A attended deceased from
January 9, 1961 to March 1, 1961....., death is said to
have occurred on the date stated above, at 4:05 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Brain tumor, glioblastoma,
multifocal left occipital lobe

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NoWhat test confirmed diagnosis? Clinical & Lab Findings

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Kenneth Briggs

M. D.

(PRINT OR TYPE SIGNATURE)

(Address) VAH Boston, Mass. Date Mar. 1 19616 Winthrop Cem., Winthrop, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL March 4 1961

7 NAME OF

FUNERAL DIRECTOR

Arthur J. O'MaleyADDRESS 79 Atlantic St., Winthrop, Mass.

Recorded and filed

MAR 3 1961Charles A. Inack

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHOUT - OF - TOWN
To be filed for burial permit
with Board of Health
or its Agent.Registered No. 02136St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{ (Was deceased a
U. S. War Veteran,
if so specify WAR)

W.I.

(a) Residence, No.

19 George

(Usual place of abode)

St.

Winthrop, Mass.

(If non-resident, give city or town and State)

Length of stay: In place of death years 1 months 20 days. In place of residence. 64 years months days.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of Hazel V. Phillips

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 65 Years 0 Months 8 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Salorman

(Kind of work done during most of working life)

14 Industry

or Business: 013 05 6331

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

BrightonMassachusetts

17 NAME OF

FATHER

Joseph W.

18 BIRTHPLACE OF

FATHER (City)

Nova Scotia

(State or country)

Canada

19 MAIDEN NAME

OF MOTHER

Martha Pondell

20 BIRTHPLACE OF

MOTHER (City)

Brighton

(State or country)

Massachusetts

21

Informant Hazel Berry(Address) 19 George St., Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Jacqueline Casey
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

PLACE OF DEATH

SUFFOLK
(County)
BOSTON
(City or Town)



The Commonwealth of Massachusetts
EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

To be filed for burial
permit with Board of
Health or its Agent.

Registered No. 12226

No. Veterans Administration Hosp. D.O.A.

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME John J. DeFreitas

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 25 UNDERHILL
(Usual place of abode)

St. Ward. WINTHROP MASS
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. days. How long in U. S., if of foreign birth? yrs. mos. days

PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR WHITE 5 SINGLE (write the word)
MARRIED MARRIED
WIDOWED or DIVORCED

5a If married, widowed or divorced, name of
HUSBAND of MILDRED M. FALLON
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here

8 AGE 46 Years Months Days If less than 1 day
Hours Minutes

9 Usual Occupation: CLERK

10 Industry or Business U.S. POST OFFICE

11 Social Security No. 215-07-4025

12 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS.

13 NAME OF FATHER THOMAS DEFREITAS

14 BIRTHPLACE OF FATHER (City) BAYONNE
(State or country) NEW JERSEY

15 MAIDEN NAME OF MOTHER NELLIE CONNELLY

16 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS.

17 Informant (Address) Mildred M. DeFreitas
25 Underhill St. Wintthrop
Relation, if any

I HEREBY CERTIFY that a satisfactory standard certificate of death was
filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
15410 3/3/61
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 2 1961
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person
above-named and that the CAUSE AND MANNER thereof are as follows
(If an injury was involved, state fully.)

Status epilepticus -

20 IN WHAT CITY OR TOWN WAS INJURY SUSTAINED
(Signed) Richard Ford M.D.
(Address) Date 3-3-61

21 PLACE OF BURIAL, CREMATION OR REMOVAL
(Cemetery) (City or town)

DATE OF BURIAL March 6 1961

22 NAME OF UNDERTAKER Robert W. White
ADDRESS 35 Roudout St. E. Boston

Received and filed 1961
(Registrar)

WRITE PLAINLY, WITH UNFADING BLACK INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a notation to that effect.

5M-3-58-922187

A TRUE COPY ATTEST:

Charles H. Mante

City Registrar

RECEIVED



JUN 14 1961 AM

SUFFOLK

(County)

BOSTON

(City or Town)



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

OUT-OF-TOWN

To be filed for burial permit
with Board of Health
or its Agent.

02736

Registered No.

No. Massachusetts General Hospital BAKER MEMORIAL

{If death occurred in a hospital or institution,
St. { give its NAME instead of street and number}

PHYSICIAN — IMPORTANT

2 FULL NAME WATSON C. LINDSEY

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, No
If so specify WAR)

(a) Residence No. 47 Washington Ave.
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death 2 years 2 months 2 days. In place of residence 45 years 2 months 2 days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 17, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Mar. 16, 1961, to Mar. 17, 1961
I last saw him alive on Mar. 17, 1961, death is said to
have occurred on the date stated above, at 9:10p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Edema

Due To

(b) Acute myocardial Infarction

Due To

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? YesWhat test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) C. L. Clay

Charles L. Clay, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Mar. 17, 1961

6 Winthrop
Place of Burial or Cremation

Winthrop
(City or Town)

DATE OF BURIAL March 21, 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
Winthrop Mass

ADDRESS

Received and filed Mar 22 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED

Married

10a If married, widowed, or divorced
HUSBAND of Susan Thomas

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE

67

Years

11

Months

6

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

Sales Engineer

(Kind of work done during most of working life)

14 Industry

or Business:

Title15 Social Security No. 019-14-6670

16 BIRTHPLACE (City) St Louis
(State or country) Missouri

17 NAME OF

FATHER

Watson Lindsey

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Tennessee

19 MAIDEN NAME

OF MOTHER

Lillian Crowdes

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Tennessee

21

Informant:

(Address)

Susan Lindsey47 Washington Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

[Signature]
(Signature of Agent of Board of Health or other)

1253
(Official Designation)

3/30/61
(Date of Issue of Permit)

R-301A

DUCTIONS
OR
CERTIFICATE

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OF DEATH

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Chapter 137,
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48. Acts of
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Direction

use only

K Ink.

14 1961

028143

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS
 MEDICAL EXAMINER'S
 CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
 with Board of Health
 or its Agent.

Registered No.

02735

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME KATHLEEN (JENKS) ARMSTRONG

(First Name) (Middle Name) (Last Name)
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
 (Was deceased a
 U. S. War Veteran,
 If so specify WAR)

(a) Residence, No. 332 PLEASANT STREET St. WINTHROP
 (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 3 days In place of residence 4 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 18 1961
 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

THERMAL BURNS OF SKIN, TRACHEA
 AND BRONCHI

5 Accident, suicide, or homicide (specify) ACCIDENT

Date and hour of injury MARCH 15 1961

IF ACCIDENTAL, was injury causally related to the death? YES

Where did injury occur? WINTHROP, MASSACHUSETTS
 (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? HOME
 (Specify type of place)

Manner of injury CONFLAGRATION CAUSED BY CIGARETTE
 (How did injury occur?)

Nature of injury THERMAL BURNS

While at work? Was autopsy performed? YES

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) LEON J. SINS, M.D.

(Print or Type Signature)

(Address) 25 SHATTUCK ST. Date MARCH 19, 1961

7 HOLY CROSS MALDEN

Place of burial, or Cremation (City or Town)

DATE OF BURIAL MAR 22 1961

8 NAME OF FUNERAL DIRECTOR Gerard C. Connell

ADDRESS 22 Salem St. Malden

Received and filed MAR 19 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)
 MARRIED WIDOWED WIDOWED
 or DIVORCED

Female White

11a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of DAVID ARMSTRONG
 (Husband's name in full)

12 IF STILLBORN, enter that here.

13 AGE 62 Years 2 Months 2 Days If under 24 hours
 Hours Minutes

14 Usual Occupation: HOME
 (Kind of work done during most of working life)

15 Industry or Business: HOMEWORK

16 Social Security No.

17 BIRTH (City) BOSTON
 State or Country MASS

18 NAME OF FATHER MARTIN Jenks

19 BIRTHPLACE OF FATHER (City) IRELAND
 (State or country)

20 MAIDEN NAME OF MOTHER CATHERINE BURKE

21 BIRTHPLACE OF MOTHER (City) IRELAND
 (State or country)

22 Informant MARGARET CONVERY
 (Address) 24 PACIFIC ST. MALDEN

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

1352 3/20/61
 (Official Designation) (Date of Issue of Permit)

Information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 34, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 41-44.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 16, requires physicians to insert a recital to that effect.

509-6-60-923115

14 1961

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

R-301A

DUCTIONS
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CERTIFICATEIVING
OF DEATHt enter
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of dying,
part failure,
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or compli-
which causeds, if any,
ve rise to
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ath but not
the terminal
dition givenChapter 137,
954, requires
s to print or
cause on
of death on
ificates, and
48 Acts of
Physi-
ature.

Director

only

Ink.

14 1961

028145

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

2 FULL NAME Mary Dodge

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 54 Buchanan Street

(Usual place of abode)

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a

No

{U. S. War Veteran,

{If so specify WAR)

St. Winthrop, Massachusetts

(If nonresident, give city or town and State)

Length of stay: In place of death, years months 7 days. In place of residence, 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 28 1961
(Month) (Day) (Year)

I HEREBY CERTIFY that the deceased died on March 21 1961 at 8:07 a.m.

we last saw her alive on March 28 1961, death is said to have occurred on the date stated above, at 8:07 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) INTRACEREBRAL HEMORRAGE

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Charles L. Cloy, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Asst. Dir., Mass. Gen'l Hosp. Date Mar. 28 1961

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 31 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS

Winthrop Mass.

Received and filed MAR 30 1961

Charles H. Mackay (Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT-OF-TOWN

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 13011

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
OR DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Arthur D. Dodge

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 71 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Housewife

(Kind of work done during most of working life)

14 Industry

or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston
(State or country) Mass

17 NAME OF FATHER

Peter Christopher

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Newfoundland

19 MAIDEN NAME

OF MOTHER

Bridget Fitzgibbons

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21

Informant

(Address)

Helon Christopher

11 Revere St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Jacqueline Casey
(Signature of Agent of Board of Health or other)A 14 24 3/29/61
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
or, or compli-
catedms, if any,
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ause (a),
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ause lastions contrib-
ruth but not
the terminal
dition givenChapter 137,
1954, requires
to print or
the cause of
death on
certificates, and
4b. Acts of
Physi-
print or type
signature

c.

14 1961

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)

No.

Beth Israel Hospital St.

2 FULL NAME

Dr. Reuben Guralnick

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No

(Usual place of abode)

122 Washington Ave

St.

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death years months 1 day In place of residence 30 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

March 30 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY. That I attended deceased from
March 29 1961, to March 30 1961I last saw him alive on March 30, 1961, death is said to
have occurred on the date stated above, at 3:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL INFARCTION

INTERVAL
BETWEEN
ONSET AND
DEATH
10 hrsDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSATHEROSCLEROTIC HEART
DISEASE

Was autopsy performed? YES

What test confirmed diagnosis? AUTOPSY

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Arnold Rosenblatt, M.D.

Gerald Rosenblatt

(PRINT OR TYPE SIGNATURE)

(Address) 330 Brookline Ave Boston 3-30 1961

6 Chel Jacob

Place of Burial or Cremation

Woburn

(City or Town)

DATE OF BURIAL

March 31 1961

7 NAME OF

FUNERAL DIRECTOR

Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed

APR 2 1961

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT OF TOWN

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 03071

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED Married
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of Nina Hazman

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 78 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

Pediatrician

(Kind of work done during most of working life)

14 Industry

or Business:

Medicine

15 Social Security No.

16 BIRTHPLACE (City)

Russia

(State or country)

17 NAME OF
FATHER

(unknown) Guralnick

18 BIRTHPLACE OF

FATHER (City)

Russia

(State or country)

19 MAIDEN NAME

OF MOTHER

(unknown)

20 BIRTHPLACE OF

MOTHER (City)

Russia

(State or country)

21

Informant

(Address)

Dr. Walter C. Guralnick

118 Wallis Rd., Chst Hill

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transfer permit was issued.

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

RECEIVED
City Registrar



JUN 14 1961 AM

PLACE OF DEATH

Suffolk
(County)Roxbury
(City or Town)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent.

Registered No.

03235

No. Robt. B. Brigham Hospital St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME Mrs. MARY BAUMEISTER (Waters)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 12 Prospect Ave. Winthrop
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months 5 days. In place of residence 26 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 2 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
MAR 28 1961 to APRIL 1 1961I last saw her live on April 1 1961, death is said to
have occurred on the date stated above, at 2:02 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART Dis.

15 yrs

Due To (b) GEN. ARTERIOSCLEROSIS 20 yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS SCOLIOSIS 60 yrs
RHEUMATOID ARTHRITIS 10 yrs

Was autopsy performed?

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Theodore Feldman, M. D.

(Address) 454 BROOKLINE Ave. Apr. 2 1961

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 5, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed APR 6 1961

Charles H. Thacker (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

F

9 COLOR

W.

10 SINGLE (write the word),
MARRIED MARRIED
WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Fred D. Baumeister
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 69 Years 1 Months 23 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Housewife

(Kind of work done during most of working life)

14 Industry

or Business:

Own Home

15 Social Security No. none

16 BIRTHPLACE (City)

(State or country)

No. HARTLAND
VERMONT

17 NAME OF FATHER

Julian Waters

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Vermont

19 MAIDEN NAME

OF MOTHER

Bessie Perrce

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

White River Jct.
Vermont

21

Informant (Address)

Fred A. Baumeister

12 Prospect Ave, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Mass. J. Cronin

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

14 1961

M-5-57920345

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

To be filed for burial permit
with Board of Health
or its Agent.

97

R-301A

PLACE OF DEATH

BOSTON
(County)

MASS

(City or Town)

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 143428

No. CHILDREN'S HOSPITAL MEDICAL CENTER If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

HARRIS RUDGIN

PHYSICIAN — IMPORTANT

2 FULL NAME (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, No
if so specify WAR)(a) Residence, No. 171 SHORE DRIVE, WINTHROP, MASS St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months days In place of residence 4 years 10 months 21 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 7, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
APRIL 7, 61, to APRIL 7, 61I last saw him live on APRIL 7, 61, death is said to
have occurred on the date stated above, at 5:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) SUBARACHNOID HEMORRHAGE

INTERVAL
BETWEEN
ONSET AND
DEATH
9 HOURS

Due to (b) INTRACRANIAL METASTASES

Due to (c) DISSEMINATED NEUROBLASTOMA YEAR

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? YES.

What test confirmed diagnosis? Autopsy.

5 Was disease or injury in any way related to occupation of deceased?
If so, specify NO

(Signed) J. Silverstone, M. D.

300 LONGWOOD AVE. (PRINT OR TYPE SIGNATURE)

(Address) DATE APRIL 8, 61

6 TIFERETH ISRAEL OF WINTHROP - ERECT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 9, 1961

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLD

ADDRESS 1662 BENJAMIN ST. BOSTON, MASS

Received and filed APR 11 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED SINGLE
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 4 Years 10 Months 21 Days If under 24 hours
Hours Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.:

16 BIRTHPLACE (City) WINTHROP, MASS
(State or country)

17 NAME OF FATHER SIDNEY RUDGIN

18 BIRTHPLACE OF FATHER (City) BOSTON, MASS
(State or country)

19 MAIDEN NAME OF MOTHER LOUISE BARSKY

20 BIRTHPLACE OF MOTHER (City) BOSTON, MASS
(State or country)21 Informant (Address) HAROLD KOWITZ
11 LAVER LANE, WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

DUCTIONS
OR
CERTIFICATEiving
OF DEATHot enter
than one
for each
b) and (c)s not mean
of dying,
cart failure,
i.e. It means
or compli-
which causeds, if any,
ive rise to
ause (a),
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ause last.ions contrib-
uth but not
the terminal
dition given

1934

Chapter 137,
254, requires
is to print or
cause or
death on
ificates, and
48. Acts of
ures Physi-
print or type
er signature.

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14 1961

028145

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar RECEIVED



JUN 14 1961 AM

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

03813

Registered No.

STANDARD
CERTIFICATE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

{If death occurred in a hospital or institution,
St. { give its NAME instead of street and number}

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
If so specify WAR)

2 FULL NAME Jennie Gruszecki

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 142 Pleasant Street
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months..... days. In place of residence..... years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 18 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That we attended deceased from
April 11, 1961 to April 18, 1961We last saw her alive on April 18, 1961 death is said to
have occurred on the date stated above, at 3:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Obstructive Emphysema

Due To

(b) Acute Tracheo Bronchitis, 9 days

Due To

(c) Purulent (Staph.)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed)

Charles L. Cloy, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date April 18, 61

6 St Michael's - Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April - 22 - 1961

7 NAME OF FUNERAL DIRECTOR F. H. Pocharski

ADDRESS

Cambridge Mass.
Received and filed APR 25 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
OR DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

John J. Gruszecki
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

63 Years - Months - Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

House - Wife

(Kind of work done during most of working life)

14 Industry

or Business:

At Home

15 Social Security No.

None

16 BIRTHPLACE (City

(State or country)

Smietyn Poland

17 NAME OF

FATHER

Humphrey Kulczycki

18 BIRTHPLACE OF

FATHER (City

(State or country)

Smietyn Poland

19 MAIDEN NAME

OF MOTHER

Catherine Bazynuk

20 BIRTHPLACE OF

MOTHER (City

(State or country)

Smietyn Poland

21 Informant

(Address)

Edw. Gruszecki - Son

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued:

F. H. Pocharski

(Signature of Agent of Board of Health or other)

1725

(Official Designation)

4-20-61

(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
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for each
b) and (c)es not mean
of dying,
arary failure,
etc. It means
or, or compli-
which causedmr. if any,
ave rise to
cause (a),
the under-
cause last.ions contrib-
rath but not
the terminal
dition given

60

Chapter 137,
1954, requires
ns to print or
the cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
der signature.

Director

so only

ink.

N 16 196

1928145

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT - OF - TOWN 100

To be filed for burial permit
with Board of Health
or its Agent.

03856

Registered No.

No. Veterans Administration Hospital

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Raleigh Calvin BROWN

(First Name) (Middle Name) (Last Name)
(It deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) WWII(a) Residence, No. 120 Croot Ave.
(Usual place of abode)xx Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death 0 years, 0 months, -1 days. In place of residence 3 years, months, days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Apr. 20 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Apr. 20 1961 to Apr. 20 1961death is said to
have occurred on the date stated above, at 8:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of the lung with
metastasis to the brain.INTERVAL
BETWEEN
ONSET AND
DEATH
2 yrsDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Clinical & Lab Findings5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) John S. Walton M.D.
John S. Walton
(PRINT OR TYPE SIGNATURE)
(Address) VAR, Boston, Mass. Date Apr. 21 19616 Cambridge Cem., Cambridge, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 24 1961

7 NAME OF FUNERAL DIRECTOR A. E. Long & Son

ADDRESS 1979 Massachusetts Ave., Cambridge, Mass.

Received and filed APR 25 1961

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED WIDOWED
or DIVORCED or DIVORCED10a If married, widowed, or divorced, Alma
HUSBAND of Elizabeth White
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years 11 Months 24 Days If under 24 hours
Hours Minutes13 Usual Occupation: radiator
(Kind of work done during most of working life)

14 Industry or Business: Logan Airport, Boston, Mass.

15 Social Security No. C-100

16 BIRTHPLACE (City) Casey
(State or country) Illinois17 NAME OF FATHER Elonzo
Elonzo Brown18 BIRTHPLACE OF FATHER (City) Casey
(State or country) Illinois

19 MAIDEN NAME OF MOTHER Docia can not be learned

20 BIRTHPLACE OF MOTHER (City) Casey
(State or country) Illinois21 Informant V. A. Hospital Records, 150 S.
(Address) Huntington Ave., Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)1755 4-21-61
(Official Designation) (Date of Issue of Permit)DUPLICATIONS
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14 1961

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

45/11

RECEIVED



JUN 14 1961 AM

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHRegistered No. **03910**

Suffolk

(County)

Boston

(City or Town)

No. **Veterans Administration Hospital**(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

RAYMOND J. KENNEY

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, **WWI**
If so specify WAR)(a) Residence, Nu.
(Usual place of abode)**4 Linden**St. **Winthrop, Mass.**

(If nonresident, give city or town and State)

Length of stay In place of death years months **16** days In place of residence **70** years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April 20 1961**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 4 1961 to April 20 1961death is said to
have occurred on the date stated above, at **4:25 P.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **1. Bronchopneumonia**Due To **2. Congestive heart failure**Due To
(c)OTHER
SIGNIFICANT
CONDITIONS **Anemia**INTERVAL
BETWEEN
ONSET AND
DEATH
days**unk**Was autopsy performed? **No**What test confirmed diagnosis? **Clinical & Lab Findings**5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed)

Robert H. Saville

(PRINT OR TYPE SIGNATURE)

(Address) **VAH Boston, Mass. Date April 20 1961**6 **Winthrop Cem., Winthrop, Mass.**

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL **April 24 1961**7 NAME OF FUNERAL DIRECTOR **Arthur O'Maley**
79 Atlantic StreetADDRESS **Winthrop, Mass.**Received and filed **APR 25 1961****Charles H. Inactive**
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or **DIVORCED**

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 70 Years 5 Months 19 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: **Machinist**

(Kind of work done during most of working life)

14 Industry

or Business:

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Newburyport
Massachusetts

17 NAME OF FATHER

William B.

18 BIRTHPLACE OF FATHER (City)

(State or country)

Boston

(State or country)

Massachusetts

19 MAIDEN NAME

OF MOTHER

Johanna Ready

20 BIRTHPLACE OF MOTHER (City)

(State or country)

21

Informant **VA Hospital Records, 150 South**
(Address) **Huntington Ave., Boston, Mass.**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or cremation.**Don't M. [Signature]**
(Signature of Agent of Board of Health or other)414556
(Official Designation)4/23/61
(Date of Issue of permit)

R-301A

INSTRUCTIONS
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OF DEATHnot enter
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er signature.

C.

14 1961

028145

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar RECEIVED



JUN 14 1961 AM

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent

103072

Registered No. _____

2 FULL NAME Nora Rawston

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

457 Winthrop St. Winthrop, Mass.

(a) Residence No. _____
(Usual place of abode)

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
{ U. S. War Veteran,
{ if so specify WAR) No

(If nonresident, give city or town and State)

Length of stay: In place of death _____ years _____ months 10 days. In place of residence 25 years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 23, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY That we attended deceased from
Apr. 13, 1961, to Apr. 23, 1961.

We last saw him alive on Apr. 23, 1961, death is said to
have occurred on the date stated above, at 7:00A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Infarction, lt. cerebral hemisphere

(b) Due To Cerebral embolus

(c) Due To Myocardial infarction and mural thrombus, lt. vent. 10 days

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Charles L. Cloy, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Apr. 23, 61

6 Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 26, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed _____ 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of _____

(Give maiden name of wife in full)

(or) WIFE of Robert Rawston

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

AGE 60 Years _____ Months _____ Days

If under 24 hours
_____ Hours _____ Minutes

12 Usual Occupation: Clerk

(Kind of work done during most of working life)

Industry or Business: U.S. Service Store

15 Social Security No. 15-16-9572

16 BIRTHPLACE (City) Fall River
(State or country) Mass

17 NAME OF FATHER Austin Tierney

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER

Annie Maloney

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21 Informant Robert Rawston

(Address) 459 Winthrop St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

1796 (Official Designation)

4-25-61 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



JUN 14 1961 AM

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16 1961

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

2 FULL NAME

John Mac Queen

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence No.
(Usual place of abode)

31 Charles Street

St Winthrop, Massachusetts

(If nonresident, give city or town and State)

Length of stay: In place of death years months 11 days In place of residence 40 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 26 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
April 15 61 to April 26 61
We last saw him alive on April 26 19 61, death is said to

have occurred on the date stated above, at 5:27a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary emboli

INTERVAL
BETWEEN
ONSET AND
DEATH

5 days

Due To (b) Thrombophlebitis, leg veins 2 weeks

Due To (c)

OTHER SIGNIFICANT CONDITIONS Hypertensive heart disease
Cerebral infarcts 5 years

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M. D.

Charles L. Clay, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Asst. Dir., Mass. Gen'l. Hosp., Date April 26 61

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 29 1961

7 NAME OF FUNERAL DIRECTOR

Celfred B. Mars

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAY 2 1961

Charles J. MacQueen (Registrar)

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No.

041107

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Joyce Helena Baker
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 3 Months 13 Days If under 24 hours
Hours MinutesUsual Occupation: retired carpenter-contractor
(Kind of work done during most of working life)

14 Industry or Business: self employed

15 Social Security No. 011 - 20 - 0728

16 BIRTHPLACE (City) Whycocomah
(State or country) Nova Scotia

17 NAME OF FATHER Angus MacQueen

18 BIRTHPLACE OF FATHER (City) Whycocomah
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Sarah MacLean

20 BIRTHPLACE OF MOTHER (City) Whycocomah
(State or country) Nova ScotiaInformant Mrs. John W. MacQueen
(Address) 31 Charles St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued

Signature of Agent of Board of Health or other

1854 4-28-61
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST

Charles H. Mackie

City Registrar

PLACE OF DEATH

SUFFOLK

BOSTON

(City or Town)

Massachusetts General Hospital BAKER MEMORIAL

No.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent.

Registered No.

04106

2 FULL NAME **Silvio Calla**

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U S War Veteran
if so specify WAR)No
i(a) Residence. No. **70 Banks**
(Usual place of abode)St. **Winthrop, Massachusetts**
(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. days. In place of residence. years. months. days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April 27, 1961**
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
April 27, 1961, to April 27, 1961
I last saw him live on **April 27, 1961**, death is said tohave occurred on the date stated above, at **3:50 P.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Dissecting aneurysm**Due of ascending aortic arch
(b) **with attempted operative**Due To repair
(c)OTHER SIGNIFICANT CONDITIONS
Aortic valvular insufficiencyWas autopsy performed? **No**What test confirmed diagnosis? **Clinical**5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) **C. L. Clay**, M. D.
Charles L. Clay, M.D.
(PRINT OR TYPE SIGNATURE)(Address) **Ass't. Dir., Mass. Gen'l. Hosp.** Date **4-27-1961**6 **Holy Cross** **Malden**
Place of Burial or Cremation (City or Town)DATE OF BURIAL **MAY 1ST**, 19617 NAME OF FUNERAL DIRECTOR **RICHARD C KIRBY INC.**ADDRESS **217 BENNINGTON ST. E. BOSTON**Received and filed **MAY 2 1961****Charles J. Mackie**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

W10 SINGLE (write the word)
MARRIED
WIDOWED **MARRIED**
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of **Concetta Grasso**
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE **47** Years **0** Months **3** Days

If under 24 hours

Hours. Minutes

13 Usual

Occupation: **SHEET METAL WORKER**
(Kind of work done during most of working life)

14 Industry

or Business: **BOSTON NAVY YARD**

15 Social Security No.

070-01-408616 BIRTHPLACE (City)
(State or country)**E. Boston**
Mass

17 NAME OF FATHER

NICODEMO CALLA

18 BIRTHPLACE OF

FATHER (City)

(State or country)

ITALY

19 MAIDEN NAME

OF MOTHER

AELINE CENSULLO

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

ITALY

21

Informant

(Address)

MRS. CONCETTA CALLA (WIFE)
70 BANKS ST WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

1852

(Official Designation)

4-28-61

(Date of Issue of Permit)

A TRUE COPY ATTEST

Charles H. Mackie

City Registrar

395
R-301A

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

01087 105

To be filed for burial permit
with Board of Health
or its Agent

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. **28**

No. **BOSTON SANATORIUM**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

WALTER E. FALLON

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a

{ U. S. War Veteran.

{ if so specify WAR)

W.W.II

(a) Residence, No.

(Usual place of abode)

25 Underhill Street, Winthrop

St. (If nonresident, give city or town and State)

Length of stay In place of death 0 years 0 months 2 days In place of residence years 3 months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 27 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I attended deceased from April 25 1961 to April 27 1961
I last saw him live on April 27 1961, death is said to have occurred on the date stated above, at 1:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia

Due To

(b) Pulmonary Abscess

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) *Benson S. Charif*
Benson S. Charif, M.D.

(Address) 249 River St., April 28, 61

Holy Cross *Malden*
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *May 1* 1961

7 NAME OF FUNERAL DIRECTOR *John T. White*

ADDRESS *105 London St. Boston*

Received and filed *MAY 20 1961*

Charles A. Inactive (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word) **MARRIED**
MARRIED WIDOWED OR DIVORCED

10a If married, widowed or divorced HUSBAND of **CATHERINE RUTLEDGE**
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **37** Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: **WAITER**
(Kind of work done during most of working life)

14 Industry or Business: **ESSEX FOOD SHOP INC.**

15 Social Security No. **017-05-1843**

16 BIRTHPLACE (City) **BOSTON**
(State or country) **MASS**

17 NAME OF FATHER **VINCENT FALLON**

18 BIRTHPLACE OF FATHER (City) **BOSTON**
(State or country) **MASS.**

19 MAIDEN NAME OF MOTHER **JULIA DELAHANTY**

20 BIRTHPLACE OF MOTHER (City) **BOSTON**
(State or country) **MASS**

21 Informant (Address) *Medical Dept. Hospital*
25 Underhill St. Winthrop

I HEREBY CERTIFY that satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Edward W. Waller
(Signature of Agent of Board of Health or other)

A16689 **April 28, 1961**
(Official Designation) (Date of Issue of Permit)

INSTRUCTIONS
FOR
CERTIFICATE

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OF DEATH

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Chapter 137,
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Charles H. Macfie
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16 196

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No.

04209

Suffolk

(County)

E. Boston

(City or Town)

No. Princeton-Shelby Nursing Home

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Mary Ann Davy

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
(U. S. War Veteran,
(if so specify WAR)

NO.

(a) Residence, No. 140 River Road
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death years 1 months 21 days In place of residence 52 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 29 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
APRIL 26, 1954, to APRIL 29, 1961I last saw alive on APRIL 28, 1961, death is said to
have occurred on the date stated above, at 1:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERALIZED ARTERIO SCLEROSIS

Due To
(b) ARTERIO SCLEROSISDue To
(c) HYPERTENSIONOTHER
SIGNIFICANT DIABETES MELLITUS
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH

4 YEARS

10 YEARS

7 YEARS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Dorothy Cheney Appleton, M. D.
DOROTHY CHENEY APPLETON
(PRINT OR TYPE SIGNATURE)

(Address) 192 Wabash St. Date APRIL 29, 1961

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 1, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAY 2, 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Charles William Davy
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 87 Years 4 Months 15 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: housewife

(Kind of work done during most of working life)

14 Industry

or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City)

(State or country) East Boston
Massachusetts

17 NAME OF

FATHER Mark Evans

18 BIRTHPLACE OF

FATHER (City)

(State or country) Germany

19 MAIDEN NAME

OF MOTHER

unable to obtain

20 BIRTHPLACE OF

MOTHER (City)

(State or country) Lowell
Massachusetts

21

Informant

(Address)

Mrs. Fred H. Everbeck

140 River Road, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Jacqueline Dorato

(Signature of Agent of Board of Health or other)

1887

(Official Designation)

5 1 61

(Date of Issue of Permit)

A TRUE COPY ATTEST

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

107

M R-301A

Suffolk

(County)

Boston

(City or Town)



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD

CERTIFICATE OF DEATH

Registered No. 04216

No. Veterans Administration Hospital

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME JOHN A. FLYNN

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a

U. S. War Veteran.

{if so specify WAR

WWI

(a) Residence No.

70 Waldemar Avenue

Winthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months 27 days In place of residence 1 year months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 29 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from April 2 19 61 to April 29 19 61

death is said to have occurred on the date stated above, at 8:00 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Carcinoma of the lung with

metastases to brain and lungs.

(a)

(b)

(c)

(d)

(e)

(f)

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A TRUE COPY ATTEST

Charles H. Mackie

City Registrar

PLACE OF DEATH

SUFFOLK Suffolk
(County)
BOSTON Boston
(City or Town)JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No.

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Jean Britcher (Forrest)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name)(Was deceased a
U. S. War Veteran
if so specify WAR)(a) Residence, No. 46 Nevada Street
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay. In place of death years months days. In place of residence 6 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 2 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from April 6 1961 to May 2 1961
We last saw him alive on May 2 1961 death is said to have occurred on the date stated above, at 9:25 a.m.INTERVAL
BETWEEN
ONSET AND
DEATH

24 HRS

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) uremia

Due To (b) Diabetic nephropathy 20 yrs

Due To (c) diabetes mellitus 32 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Charles L. Cloy, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ann't. Dis. Mon. Gen'l. Hosp. Date May 2 1961

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 5 1961

7 NAME OF FUNERAL DIRECTOR Mabel G. Curnane

ADDRESS 505 Broadway, Everett, Mass.

Received and filed MAY 8 1961
Charles H. Inackel (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE Married
MARRIED
WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Raymond Britcher
(Husband's name in full)

11 IF STILL BORN, enter that fact here.

12 AGE 37 Years Months Days 11 under 24 hours
Hours Minutes13 Usual Occupation: Co-owner
(Kind of work done during most of working life)

14 Industry or Business: Pet Shop

15 Social Security No. 029-30-8629

16 BIRTHPLACE (City) Montreal Canada
(State or country)

17 NAME OF FATHER John Forrest

18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)

19 MAIDEN NAME OF MOTHER Cobl. Ross

20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)21 Informant Raymond Britcher
(Address) 46 Nevada St. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with the BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

1957 5-4-61
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST

Charles R. Mackie

City Recorder

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-8-56-918227

PLACE OF DEATH

Essex
(County)

Lynn
(City or Town)

No. Lynnview Hospital

2 FULL NAME Mary Ciampa (Powers)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 41 Paine
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 6.....days. In place of residence 14.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 1, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

19 61 to June 1, 19 61
I last saw alive on May 27, 19 61 death is said to
have occurred on the date stated above, at 4:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis, generalized

Due To (b) Carcinoma of endometrium 1 yr.

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Clarence London, M. D.

(Address) Lynnview Hosp. Date June 2/61

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 5, 19 61

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed.....19.....

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. 109

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

(Was deceased a U. S. War Veteran, if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED married

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Frank Ciampa (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years 1 Months 0 Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 16 BIRTHPLACE (City) East Boston (State or country) Mass.

17 NAME OF FATHER William Powers

18 BIRTHPLACE OF FATHER (City) Alexandria (State or country) Virginia

19 MAIDEN NAME OF MOTHER Georgianna Morton

20 BIRTHPLACE OF MOTHER (City) New York (State or country)

21 Informant Frank Ciampa (Address) 41 Paine St., Winthrop

A TRUE COPY ATTEST Albert L. Lyons (Registrar of City or Town where death occurred)

DATE FILED June 6/61

~~RECEIVED~~
~~CITY CLERK'S OFFICE~~

~~JUN 9 9 45 AM '61~~

~~LYNN, MASS.~~

RECEIVED



JUN 16 1961 AM

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 110

PLACE OF DEATH

Suffolk

(County)

WINTHROP

(City or Town)

No. 12 Lewis Terrace

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME George GOLDSTEIN AKA GOULD
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran, WVI
if so specify WAR)

12 Lewis Terrace

(a) Residence, No. St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 25 years months days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 2 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw him alive on 19 death is said to
have occurred on the date stated above, at 5:05 P.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To Presumably Coronary Occlusion sudden
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? Post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray M. D.

Arthur C. Murray, M.D.

(Address) Winthrop Board of Health 2 June 1961
(PRINT OR TYPE SIGNATURE) Date6 Sharon Memorial Park Sharon
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jun 4 1961

7 NAME OF FUNERAL DIRECTOR Fisher Memorial Chapel
ADDRESS 61 1/2 WARRICK ST LAWRENCE

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
OR DIVORCED10a If married, widowed or divorced
HUSBAND of ADA GITH (Gould) (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 62 Years 4 Months 8 Days If under 24 hours
Hours Minutes13 Usual Occupation: ACCOUNTANT
(Kind of work done during most of working life)

14 Industry or Business: George Gould Acer

15 Social Security No. 033-26-4064

16 BIRTHPLACE (City) EAST Boston
(State or country) MASS

17 NAME OF FATHER ARTHUR Gould GOLDSTEIN

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)19 MAIDEN NAME BESSIE HAMILTON
OF MOTHER BESSIE (HAMILTON)20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)21 Informant ADA Gould
(Address) 12 Lewis TerraceI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



JUN - 5 1961 PM

Suffolk

(County)

Winthrop Mass.

(City or Town)

No. Winthrop Community Hospital

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 111

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, No
if so specify WAR)

2 FULL NAME

Julia (Wilson) Mulrey

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No.

49 Hermon Street

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. 2 In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

June

7

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
6/4/1961, to 6/7/1961I last saw her alive on 6/7/1961, death is said to
have occurred on the date stated above, at 7:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

Due To

(b)

(c)

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed)

Charles

Charles

(Address)

Winthrop, Mass.

Date

6/7/1961

6

Winthrop Cemetery

Winthrop

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

June 10,

1961

7 NAME OF
FUNERAL DIRECTOR

Arthur J. O'Maley

Winthrop, Mass.

ADDRESS

Received and filed

JUN 12 1961

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Albert J. Mulrey

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

72

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

Housekeeper

(Kind of work done during most of working life)

14 Industry

or Business:

Home

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Charlestown

Mass

17 NAME OF
FATHER

Joseph Wilson

18 BIRTHPLACE OF
FATHER (City)

(State or country)

Finland

19 MAIDEN NAME
OF MOTHER

Margaret McKeon

20 BIRTHPLACE OF
MOTHER (City)

(State or country)

Boston

Mass

21 Informant

(Address)

Eileen Wilson

49 Hermon St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

M R-301A

INSTRUCTIONS
FOR
L CERTIFICATEgiving
OF DEATHnot enter
e than one
e for each
(b) and (c)does not mean
de of dying,
heart failure,
etc. It means
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which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
o the terminal
condition givenChapter 137,
f 1954, requires
ians to print or
the cause or
of death on
certificates, and
r 48, Acts of
requires Physi-
o print or type
under signature.

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

JUN 12 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

1

Suffolk
County
Winthrop
(City or Town)

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 112

No. 10 Surfside Ave St. (If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME Mary E. Stevens (First Name) (Middle Name) (Last Name)
(If deceased was married, widowed or divorced woman, give also maiden name.)
(a) Residence, No. 10 Surfside Ave Winthrop Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months days In place of residence 38 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 10 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

ARTERIO SCLEROTIC HEART DISEASE
ACUTE CONGESTIVE HEART
FAILURE

5 Accident, suicide, or homicide (specify) _____
Date and hour of injury _____ 19 _____

IF ACCIDENTAL, was injury causally related to the death? _____

Where did
Injury occur? _____
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? _____
(Specify type of place)

Manner of
Injury _____
(How did injury occur?)

Nature of
Injury _____

While at work? _____ Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Michael A. Luongo M. D.

(Address) Boston Date 6/11 19 61

7 Holy Cross Malden
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL June 13, 1961

8 NAME OF FUNERAL DIRECTOR FRANK H. CARR
ADDRESS 79 Elm St., Charlestown

Received and filed JUN 12 1961 19 _____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED Single or DIVORCED

11a If married, widowed, or divorced HUSBAND of _____ (Give maiden name of wife in full)

(or) WIFE of _____ (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 69 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation: Clerk (Kind of work done during most of working life)

15 Industry or Business: Brine's Sporting Goods Co.

16 Social Security No. 032-03-3937

17 BIRTHPLACE (City) Somerville (State or country) Mass.

18 NAME OF FATHER Charles Edward Stevens

19 BIRTHPLACE OF FATHER (City) St. Johns (State or country) N.B., Canada

20 MAIDEN NAME OF MOTHER Mary Emma Armstrong

21 BIRTHPLACE OF MOTHER (City) Lunenburg (State or country) Nova Scotia

22 Informant Mrs. Mary E. Taylor (Address) 10 Surfside Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



JUN 12 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 113

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ernest Gibson Munn

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 5 Hillside Avenue
(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death years months 4 days. In place of residence 43 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 14 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
8 Sept 19 58 to 14 June 61
1 last saw him alive on 14 June 61, death is said to
have occurred on the date stated above, at 1:10 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

Due To (b) Carcinoma of Larynx

Due To (c) - - - - -

OTHER
SIGNIFICANT
CONDITIONS NoneWas autopsy performed? No
What test confirmed diagnosis? Biopsy MGH 19595 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Arthur C. Murray, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 15 June 61

6 Edson Lowell
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 16 19 61

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed JUN 20 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Agnes Brown
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 81 2 15
AGE Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Engineer
(Kind of work done during most of working life)

14 Industry or Business: architectural

15 Social Security No. 011-01-0396

16 BIRTHPLACE (City) Lowell
(State or country) Mass

17 NAME OF FATHER Frederick Munn

18 BIRTHPLACE OF FATHER (City) Sandy Hill
(State or country) New York

19 MAIDEN NAME OF MOTHER Emeline Caufield

20 BIRTHPLACE OF MOTHER (City) Lowell
(State or country) Mass.21 Informant Agnes Munn
(Address) 5 Hillside Ave. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedns, if any,
ave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
nder signature.

0-928145

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



JUN 20 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop, Mass.

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 111

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Louise (Ingalls) I. Griffin

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 15 Villa Ave., Winthrop, Mass. St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....3.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 6 17 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 4/26 1961, to 6/17 1961

I last saw her alive on 6/17 1961, death is said to have occurred on the date stated above, at 9 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCIDENT

Due To (b) ARTERIO-SCLEROTIC HEART DISEASE + KIDNEY DIS.

Due To (c)

OTHER SIGNIFICANT CONDITIONS PARTIAL UREMIA.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signed) Myron N. King, M. D.

MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 122 PLEASANT ST. WINTHROP MASS. Date 6/17 1961

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town) MASS.

DATE OF BURIAL June 20, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop

Received and filed JUN 20 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Widow

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Arthur Eugene Griffin (or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 8 Months 5 Days If under 24 hours Hours Minutes

13 Usual Occupation: At Home Housewife (Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Boston, Mass. (State or country)

17 NAME OF FATHER Frederic C. Ingalls

18 BIRTHPLACE OF FATHER (City) Boston, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Mary Munro (Ingalls)

20 BIRTHPLACE OF MOTHER (City) Paspbiac Canada (State or country)

21 Informant Dora M. Ingalls (sister)
(Address) 15 Villa Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lirion
(Signature of Agent of Board of Health or other)H.O. 6/20/61
(Official Designation) (Date of Issue of Permit)

M R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
e for each
(b) and (c)does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

C.

11-59-926662

SPACE FOR ADDITIONAL INFORMATION

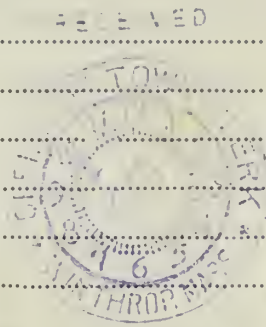
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



JUN 20 1951 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

not enter
than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Chapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 115

Suffolk

(County)

Winthrop

(City or Town)

No.

Winthrop Community Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Malloy

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

PHYSICIAN — IMPORTANT

(a) Residence. No. 98 Bradstreet Avenue
(Usual place of abode)

St. Revere, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 11 days. In place of residence 53 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 21, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

May 22, 1961, to June 21, 1961

1 last saw h. alive on June 21, 1961

death is said to have occurred on the date stated above, at 1:40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Peripheral Circulatory
Collapse

Due To Cholecysto-Jejunostomy
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS
Extensive Carcinomatosis
primary in Pancreas

Was autopsy performed? No

What test confirmed diagnosis? Lab. Tests and act

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed)

John F. Collins, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 27 Bennington Street, Revere

June 22, 1961

6 Place of Burial or Cremation

DATE OF BURIAL June 24, 1961

7 NAME OF FUNERAL DIRECTOR Arthur S. Picella

ADDRESS 876 Winthrop Ave., Revere

Received and filed JUN 23 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED

Female White

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of William T. Malloy

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 65 Years 6 Months 5 Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation: Nurses Aide

(Kind of work done during most of working life)

14 Industry

or Business: Soldiers Home

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Boston

Mass.

17 NAME OF FATHER

BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21

Informant

(Address)

Mary C. Malloy

876 Bradstreet Ave., Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Suranum

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 116

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. WINTHROP COM. HOSPITAL

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME BABY BOY MCLEOD
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence. No. 93 SHORE DRIVE, WINTHROP,
(Usual place of abode) MASS

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 27, 1961
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from
JUNE 27, 1961, to JUNE 27, 1961I last saw him alive on JUNE 27, 1961, death is said to
have occurred on the date stated above, at 19P

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CONGENITAL ATALECTASIS
OF LUNGS

Due To (b) PREMATUREITY

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) A. N. Caplan, M. D.

A. N. CAPLAN, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 186 PRINCETON ST. E. B. Date 6-28-1961

6 WINTHROP, MASS. WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JUNE 29, 19617 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS 210 WINTHROP ST. WINTHROP, MASS.

Received and filed JUN 29 1961 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED SINGLE
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years Months Days If under 24 hours
4 Hours 45 Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) WINTHROP COM. HOSPITAL
(State or country) WINTHROP, MASS.

17 NAME OF FATHER JAMES E. MCLEOD, JR.

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS.

19 MAIDEN NAME OF MOTHER EVERLYN BANDEN

20 BIRTHPLACE OF MOTHER (City) MIDDLETON
(State or country) N. H.21 Informant (Address) JAMES MCLEOD
93 SHORE DRIVE - WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sullivan
(Signature of Agent of Board of Health or other)H. O. June 29-1961
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
e for each
(h) and (c)does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
o the terminal
condition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

11-59-926662

(Registrar)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without receiving medical attendance or whose physician is absent from home when the certificate is rendered.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 117

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 97 Beach Road

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marion Virginia Hewitt (Sanborn)

(First Name) (Middle Name) (Last Name)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 97 Beach Road
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 29 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1959, to June 29, 1961

I last saw h.p. alive on June 28, 1961, death is said to have occurred on the date stated above, at 5:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Tumor of Brain

INTERVAL
BETWEEN
ONSET AND
DEATH
2 yrs.Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis Clinical - Hospital

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles L. Liberman, M.D.

Charles L. Liberman
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 6/29/1961

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 1 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Monk

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUN 29 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED married
WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of(Give maiden name of wife in full)
(or) WIFE of Hugh McKenzie Hewitt
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 50 Years 0 Months 7 Days If under 24 hours
Hours Minutes13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. C-95-63-4112

16 BIRTHPLACE (City) Rockland
(State or country) Maine

17 NAME OF FATHER James Sanborn

18 BIRTHPLACE OF FATHER (City) Machias
(State or country) Maine

19 MAIDEN NAME OF MOTHER Maude Crosby

20 BIRTHPLACE OF MOTHER (City) Machias
(State or country) Maine21 Informant Hugh M. Hewitt
(Address) 97 Beach Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

(Official Designation)

(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
b) and (c)es not mean
of dying,
heart failure,
tc. It means
or compli-
which causedas, if any,
ive rise to
ause (a),
he under-
ause last.ions contrib-
death but not
the terminal
dition givenChapter 137,
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ns to print or
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of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

928145

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop

(City or Town)

No.

41 Washington Ave

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No.

118

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)}2 FULL NAME Laura E Land
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 41 Washington Ave
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death. 2 years.....months.....days. In place of residence. 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 29 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY. That I attended deceased from
Jan 29, 1961, to June 29, 1961
I last saw him alive on June 27, 1961, death is said to
have occurred on the date stated above, at 8:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) arteriosclerosis
Heart Disease(b) arteriosclerosis
generalized

(c) Senility

OTHER SIGNIFICANT CONDITIONS Huntington's
chorea

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Joseph Gregorie, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 124 West Avenue Date 6-30-61

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 3, 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed July 5, 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
Charles Land
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 84 AGE Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Belfast
(State or country) Maine

17 NAME OF FATHER George Wentworth

18 BIRTHPLACE OF FATHER (City) Waldo
(State or country) Maine

19 MAIDEN NAME OF MOTHER Lydia Johnson

20 BIRTHPLACE OF MOTHER (City) Exeter
(State or country) Maine21 Informant Mabelle Masterson
(Address) 92 Putnam St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

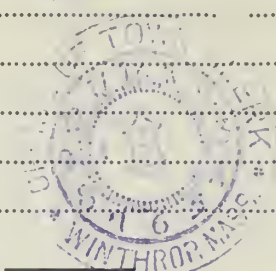
(Official Designation) (Date of Issue of Permit) 7/3/61

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
e for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
se, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
o the terminal
condition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

11-59-926662

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these rules is the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

PLACE OF DEATH

Suffolk=

(County)

Winthrop

(City or Town)

No. 45 Nahant Avenue

Registered No. 1111

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Nellie Pied (Thompson) Brosseau

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence, No. 45 Nahant Avenue

St.

(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 30 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 1951, to 30 June 1961

I last saw her alive on 30 June 1961, death is said to have occurred on the date stated above, at 12:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Incident

INTERVAL
BETWEEN
ONSET AND
DEATH
5 days

Due To

(b) Generalized Arteriosclerosis 10 yrs

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Arthur C. Murray, M. D.

Arthur C. Murray (PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 30 June 1961

6 Woodlawn Cemetery Everett

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL July 3 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed July 5 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of John Fortunat Brosseau

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 87 Years 6 Months 20 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: housework

(Kind of work done during most of working life)

14 Industry

or Business: housewife

15 Social Security No.

16 BIRTHPLACE (City) St. John's, New Brunswick

(State or country)

Canada

Wick

17 NAME OF

FATHER Alfred B. Thompson

18 BIRTHPLACE OF

FATHER (City) St. John's, New Brunswick

(State or country)

Canada

19 MAIDEN NAME

OF MOTHER Helen McCarthy

20 BIRTHPLACE OF

MOTHER (City) Ireland

(State or country)

21

Informant Mrs. Helene Black

(Address) 43-A Nahant Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 6/30/61

Chapter 137,
954, requires
to print or
of cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
der signature.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED
JUL 13 1918
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.
763
RULES OF PRACTICE

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CERTIFICATE OF DEATH

STATE OF NEW HAMPSHIRE

TOWN OR CITY
CLERK'S NO. 5

STATE FILE NO.

1. NAME OF DECEASED (TYPE OR PRINT) Theresa Clara Kiehle		2. DATE OF DEATH (MONTH) (DAY) (YEAR) Feb 3, 1961	
3. PLACE OF DEATH A. COUNTY Rockingham		4. USUAL RESIDENCE (WHERE DECEASED LIVED, IF INSTITUTION, RESIDENCE BEFORE ADMISSION.) A. STATE Mass B. COUNTY Winthrop	
5. CITY OR TOWN Plaistow		6. CITY (INVE. ACTUAL TOWN OF RESIDENCE, NOT MAILING ADDRESS). OR TOWN Winthrop, Mass	
7. FULL NAME OF HOSPITAL OR INSTITUTION Pine Street		8. STREET (IF RURAL, GIVE LOCATION) ADDRESS Summit Ave	
9. SEX Female		10. COLOR OR RACE white	
11. MARRIED ☒ DIVORCED ☐ NEVER MARRIED ☐ WIDOWED ☐		12. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE) Harry L. Kiehle	
13. DATE OF BIRTH 62		14. USUAL OCCUPATION (KIND OF WORK DURING MOST OF LIVING LIFE, EVEN IF RETIRED) Housewife	
15. AGE (IN YEARS) 62		16. KIND OF BUSINESS OR INDUSTRY Home	
17. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) Ireland		18. CITIZEN OF WHAT COUNTRY? Lapham	
19. MOTHER'S MAIDEN NAME		20. WAS DECEASED EVER IN U.S. ARMY OR FORCE? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATE OF SERVICE) 332-03-3875	
21. INFORMANT Harry L. Kiehle		22. ADDRESS Plaistow, N.H.	
23. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) Acute Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Instant	
CONDITIONS IF ANY, WHICH HAVE BEE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST.		6 months	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(A)		24. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	
25. ACCIDENT SUICIDE HOMICIDE ☐ ☐ ☐		26. DESCRIBE HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II OF ITEM 18.)	
27. TIME OF INJURY		28. CITY, TOWN OR LOCATION COUNTY STATE	
29. INJURY OCCURRED WHILE AT WORK ☐ AT WORK ☐		30. PLACE OF INJURY (E. G., IS OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)	
31. I attended the deceased from 2/1/61 to 2/3/61 and last saw her alive on 2/1/61		32. Death occurred at 5:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.	
33. SIGNATURE R.W. Tower MD		34. ADDRESS 115 Sumner St Haverhill, Mass	
35. DATE 2/3/61		36. DATE SIGNED 2/3/61	
37. BURIAL ☒ CREMATION ☐ ENTOMBMENT ☐ REMOVAL ☐		38. DATE	
39. NAME OF CEMETERY Winthrop Cemetery		40. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass	
41. FUNERAL DIRECTOR'S SIGNATURE Maurice W. Kirby		42. COUNTERSIGNED-AGENT (CITY OR OF HEALTH) DATE	
43. DATE REC'D BY TOWN OR CITY CLERK 2/3/61		44. CLERK'S OWN SIGNATURE Pauline H. Keezer	
45. CLERK OF Plaistow		46. DATE 2/17 61	

RECEIVED



JUL 20 1961 AM

NON RESIDENT

CERTIFICATE OF DEATH
FLORIDA

STATE FILE NO. 61-008779

REGISTRAR'S NO. 42

1. PLACE OF DEATH a. COUNTY St. Lucie		CODE NO. 66-025	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY Suffolk	
b. CITY, TOWN, OR LOCATION Ft. Pierce		c. IS PLACE OF DEATH INSIDE CITY LIMITS? YES ☒ NO ☐	c. CITY, TOWN, OR LOCATION Winthrop	
d. NAME OF HOSPITAL OR INSTITUTION Ft. Pierce Mem. Hosp.		e. LENGTH OF STAY IN IS 3 days.	d. STREET ADDRESS 5 Faun Bar Ave.	
3. NAME OF DECEASED (Type or print) GEORGE EDWARD NOWELL		4. DATE OF DEATH Month Feb. Day 13 Year 1961		e. IS RESIDENCE INSIDE CITY LIMITS? YES ☒ NO ☐ ON A FARM? YES ☐ NO ☒
5. SEX M	6. COLOR OR RACE W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Sept. 19, 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto (G.E.)	9. AGE (In years last birthday) 65 If UNDER 1 YEAR: Months 65 Days 65 Hours 65 Min. 65	
11. BIRTHPLACE (State or foreign country) Farmingdale, Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Bert Nowell		14. MOTHER'S MAIDEN NAME Esther Z. Green		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service) Yes WW # 1		16. SOCIAL SECURITY NO. 023-16-9592		17. INFORMANT'S SIGNATURE Mrs. Mabel L. Nowell Address Winthrop, Massachusetts
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Lungs & heart Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____				INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. (Probable) ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE NOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour 8:00 a. m. 8:00 p. m. 8:00 m. 8:00		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		20f. CITY, TOWN, OR LOCATION Winthrop COUNTY Suffolk STATE Mass.		
21. I attended the deceased from 2-10-61 to 2-13-61 and last saw him alive on 2-13-61 Death occurred at 8:00 on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE Charles M. D.		22b. ADDRESS Ft. Pierce Fla		22c. DATE SIGNED 2-15-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-15-61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Crematory
24. FUNERAL DIRECTOR'S SIGNATURE Milton W. Gaud		24a. ADDRESS 301 N. 7th St. Ft. Pierce, Fla		24b. DATE REC'D BY LOCAL REG. 2-15-61
25. REGISTRAR'S SIGNATURE Anna T. Devison		25a. LOCATION (City, town, or county) Everett, Middlesex, Mass.		

This case legal and when properly executed and will be placed in permanent file.

This case legal and when properly executed and will be placed in permanent file.

This case legal and when properly executed and will be placed in permanent file.

This case legal and when properly executed and will be placed in permanent file.

This case legal and when properly executed and will be placed in permanent file.

V.B.

Hintrop

RECEIVED



JUL 20 1961 AM

NON RESIDENT.

CERTIFICATE OF DEATH FLORIDA

STATE FILE NO. **'61-008360**

REGISTRAR'S NO.

1. PLACE OF DEATH a. COUNTY Pinellas		CODE NO. 62-163	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY Suffolk	
b. CITY, TOWN, OR LOCATION St. Petersburg		c. IS PLACE OF DEATH INSIDE CITY LIMITS? YES ☒ NO ☐	c. CITY, TOWN, OR LOCATION Winthrop	
d. NAME OF HOSPITAL OR INSTITUTION Mound Park Hospital		e. LENGTH OF STAY IN 10 3 mos.	d. STREET ADDRESS 2 Burrill Terrace	
3. NAME OF DECEASED (Type or print) Ruth Dyer Woods		4. DATE OF DEATH February 18, 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH December 8, 1894	
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR ☐ IF UNDER 24 HRS. ☐		
10a. USUAL OCCUPATION (Gives kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Winthrop, Massachusetts
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Dyer		
14. MOTHER'S MAIDEN NAME Isabelle Webster		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 010-30-9687		17. INFORMANT'S SIGNATURE <i>Charles Woods</i> Address Winthrop, Massachusetts		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) arteriosclerosis Heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 1 week
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐		20a. (Probably) ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 4:08 A. Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		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 23 Jan 61 to 18 Feb 61 and last saw her alive on 17 Feb 61 Death occurred at 4:08 A. on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>Frank J. Greer MD</i>		22b. ADDRESS 500 7th St. Winthrop		22c. DATE SIGNED 18 Feb 61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Feb. 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Winthrop Cemetery
23d. LOCATION (City, town, or county) Winthrop, Massachusetts		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>John Rhodes</i>		25. DATE RECD. BY LOCAL REG. 2-19-61		26. REGISTRAR'S SIGNATURE <i>Emily B. Cline</i>

V.B. ✓

Spencer



JUL 20 1961 AM

DUCTIONS
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CERTIFICATEiving
OF DEATHt enter
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b) and (c)s not mean
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, or compli-
which causeds, if any,
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usc (a),
he under-
use last.ons contrib-
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the terminal
dition givenChapter 137,
954, requires
to print or
cause or
f death on
ificates, and
48, Acts of
quires Phys-
print or type
ter signature.

N.C.

Director

se only

k. Ink.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

Massachusetts General Hospital BAKER MEMORIAL

No.

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT-OF-TOWN

To be filed for burial permit
with Board of Health
or its Agent.

123

04702

Registered No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Robert Bruce

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

NO.

(a) Residence, No. 12 Elliot
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 1.....days. In place of residence 42 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 12, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
May 11, 1961 May 12, 1961I last saw him live on May 12, 1961, death is said to
have occurred on the date stated above, at 4:53 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pylonephritis, Chronic,
Active, Bilateral

Due To (b) Ureteral Obstruction

Due To (c) Bilateral
Carcinoma of ProstateOTHER
SIGNIFICANT
CONDITIONS Pulmonary EdemaINTERVAL
BETWEEN
ONSET AND
DEATH

6 wks

6 wks

unk

wks

Mins.

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) Charles L. Clay, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Asst. Dir., Mass. Gen'l. Hosp., Date 5/13/ 1961

6 Glenwood Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 16, 1961

7 NAME OF FUNERAL DIRECTOR

ADDRESS 174 Winthrop St., Winthrop, Mass.

Received and filed MAY 19 1961

Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
or DIVORCED

male

white

10a If married, widowed or divorced

HUSBAND of Jessie Flora MacArthur
(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 84 Years 8 Months 23 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: retired educator

(Kind of work done during most of working life)

14 Industry

or Business: Northeastern University

15 Social Security No. 021-26-7034

16 BIRTHPLACE (City)

(State or country)

Dundee

Scotland

17 NAME OF

FATHER

James Bruce

18 BIRTHPLACE OF

FATHER (City)

Dundee

(State or country)

Scotland

19 MAIDEN NAME

OF MOTHER

Margaret Cunningham

20 BIRTHPLACE OF

MOTHER (City)

Dundee

(State or country)

Scotland

21

Informant

(Address)

Mrs. Minnie B. Parsons

12 Elliot St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Daniel J. McNamara.

(Signature of Agent of Board of Health or other)

2105

5 16 61

(Official Designation)

(Date of Issue of Permit)

T.V. 9

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



R-301A

Suffolk

(County)

Boston, Mass

(City or Town)



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent

124

STANDARD
CERTIFICATE OF DEATH

Registered No. 04741

No. Howland Nursing Home.
55 Burroughs St., J. P.

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

John W. Kenney

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No.

197 Pauline St., Winthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... 1 months..... days. In place of residence..... 10 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

May 15, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
December 25, 19..... to May 15, 1961

I last saw him live on May 14, 1961 death is said to
have occurred on the date stated above, at 11:00 pm

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Arteriosclerotic Heart dis

(a) 5 yrs.

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To (b) Coronary Occlusion, acute 3 days

Due To (c)

OTHER SIGNIFICANT CONDITION

Malnutrition

5 yrs.

Was autopsy performed? none

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Charles Liberman, M. D.
Charles Liberman

(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 5 16 61

St. Mary's

Newburyport, Mass.

6 Place of Burial or Cremation

(City or Town)

DATE OF BURIAL May 18, 1961

7 NAME OF FUNERAL DIRECTOR

Arthur J. O'Maley

ADDRESS

Winthrop, Mass.

Received and filed

MAY 31 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCE married

10a If married, widowed, or divorced
HUSBAND of Edna Bell.

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE

73

Years..... Months..... Days

If under 24 hours

Hours..... Minutes

13 Usual Occupation: Retired Circulation Mgr.
(Kind of work done during most of working life)

14 Industry or Business:

Newspaper.

15 Social Security No.

16 BIRTHPLACE (City) (State or country)

Newburyport, Mass.

17 NAME OF FATHER

William Kenney

18 BIRTHPLACE OF FATHER (City) (State or country)

Newburyport, Mass.

19 MAIDEN NAME OF MOTHER

Johanna Ready

20 BIRTHPLACE OF MOTHER (City) (State or country)

Newfoundland

21

Informant (Address)

Elizabeth Farrington
901 Hillside Ave., Painfield

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Jacqueline Dorata
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

ONLY ATTEST:
A TRUE COPY ATTEST:

Charles H. MacKee
City Registrar



JUL 17 1961 AM

The Commonwealth of Massachusetts

OUT - OF - TOWN

PLACE OF DEATH

SUFFOLK

(County)

BOSTON, MASS

(City or Town)

PETER BENT BRIGHAM HOSPITAL

No.

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

125

Registered No. 115005

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Margaret Cawthorne

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) 70

(a) Residence, No. 49 Waldemar Ave

(Usual place of abode)

St. Wintthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death years months 3 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 24 1961

(Month)

(Day)

(Year)

I HEREBY CERTIFY That I attended deceased from
May 21 1961 to May 24 1961I last saw her alive on May 24 1961, death is said to
have occurred on the date stated above, at 6:50 AM m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Severe Generalized

Due To Arteriosclerosis with

(b)

Thrombosis of right

Due To

(c)

Coronary Artery

OTHER SIGNIFICANT CONDITIONS
Acute Myocardial Infarction 5 dys
Diabetes Mellitus 4 yrs

Was autopsy performed? Yes Autopsy

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) DR. SAUL A. ROSENBERG M. D.

(PRINT OR TYPE SIGNATURE)

PETER BENT BRIGHAM HOSP. Date May 24 1961

6 HOLY CROSS MALDEN MASS

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL MAY 27 1961

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS 210 WINTHROP ST. WINTHROP

Received and filed MAY 28 1961

Charles A. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

FEMALE

9 COLOR

WHITE

10 SINGLE (write the word)
MARRIED
WIDOWED WIDCOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of WILLIAM CAWTHORNE
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 64 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

HOUSE WIFE

(Kind of work done during most of working life)

14 Industry

or Business:

HOME

15 Social Security No.

NOT KNOWN

16 BIRTHPLACE (City)

(State or country)

EAST BOSTON

MASS.

17 NAME OF FATHER

DANIAL W. HART

18 BIRTHPLACE OF

FATHER (City)

(State or country)

BOSTON

MASS.

19 MAIDEN NAME

OF MOTHER

CATHERINE MORAN

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

CHELSEA

MASS.

21

Informant

(Address)

MRS. VIRGINIA WILDER

48 WALDEMAR AVE. WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Daniel J. McNamara

(Signature of Agent of Board of Health or other)

2267

5 25 61

(Official Designation)

(Date of Issue of Permit)

INSTRUCTIONS
FOR
AL CERTIFICATEIn giving
E OF DEATHnot enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
heart failure,
, etc. It means
ase, or compli-
which causedtions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
of 1954, requires
to print or
the cause or
of death on
certificates, and
ter 48, Acts of
requires Phys-
to print or type
under signature.

A TRUE COPY ATTEST:

Charles H. Mackie

Gwylls Harar



JUL 17 1961 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Middlesex

(County)

Tewksbury, Mass.

(City or Town)

No. TEWKSBURY HOSPITAL



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

TEWKSBURY HOSPITAL

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATHRegistered No. 126
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Irving Ross

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR. No

(a) Residence, No.

94 Faun Bar Avenue,

Wintthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 0 years 10 months 3 days. In place of residence 16 years 16 months 16 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

June 5,

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Aug. 2,

1960

to June 5,

1961

I last saw him alive on June 4,

1961

death is said to

have occurred on the date stated above, at 1:45 a.m.

INTERVAL
BETWEEN
ONSET AND
DEATH
4 dys.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Broncho-Pneumonia

Due To

(b)

Arteriosclerotic Heart
Disease

7 yrs.

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Pulmonary

Emphysema

15 yrs.

Was autopsy performed?

No

What test confirmed diagnosis? X Rays - EKG

5 Was disease or injury in any way related to occupation of deceased?

No

If so, specify

(Signed)

M. Mully Yavarow

M. D.

(Address)

TEWKSBURY HOSPITAL

Date June 5, 1961

6 Woodlawn Cemetery, Everett

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

June 8,

1961

7 NAME OF FUNERAL DIRECTOR

Ernest P. Caggiano

ADDRESS

147 Wintthrop St., Wintthrop

Received and filed

18 Sept.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE

(write the word)

MARRIED

WIDOWED

or DIVORCED

Married

10a If married, widowed, or divorced

HUSBAND of

Mary Barry

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

67

Years

3

Months

15

Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

Retired Business Man

(Kind of work done during most of working life)

14 Industry

or Business:

Tow boat operator

15 Social Security No.

011-05-6003

16 BIRTHPLACE (City)

(State or country)

East Boston
Massachusetts

17 NAME OF FATHER

Joseph Ross

18 BIRTHPLACE OF FATHER (City)

Nova Scotia

(State or country)

Canada

19 MAIDEN NAME

OF MOTHER

Sarah Smith

20 BIRTHPLACE OF MOTHER (City)

Nova Scotia

(State or country)

Canada

21

Informant

(Address)

Hospital Records

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

June 5, 1961

19

RECEIVED



JUL 21 1961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

THIS IS A PERMANENT RECORD
WRITE PLAINLY, WITH UNFADING BLACK INK APPROVED BLACK TYPEWRITER RIBBON

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

1

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 127

No. Chelsea Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gertrude Fisher (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence, No. 51 Cutler St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 8 days. In place of residence, 15 months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 12, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 4 1961 to June 12, 1961 I last saw her live on June 12, 1961, death is said to have occurred on the date stated above, at 11:55p.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) John A. Pepi M. D. (Address) 821 Saratoga St., E. Boston, Mass.

6 Beth David, Woburn, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 14, 1961

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach ADDRESS 10 Washington St., Dorchester

Received and filed 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Married

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years, Months, Days If under 24 hours Hours, Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) Roumania (State or country)

17 NAME OF FATHER Menasha Rothstein

18 BIRTHPLACE OF FATHER (City) Roumania (State or country)

19 MAIDEN NAME OF MOTHER Zelda-(cannot be learned)

20 BIRTHPLACE OF MOTHER (City) Roumania (State or country)

21 Informant Charles Fisher (Address) 51 Cutler St., Winthrop, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED June 14, 1961

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

not enter
than one
e for each
(b) and (c)

does not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

Chapter 137,
1954, requires
ans to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATHRegistered No. 128

PLACE OF DEATH

(County)

Winthrop

(City or Town)

No. Winthrop Convalescent Home{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Marianna Nowicki

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 19 Medford
(Usual place of abode)St. Chelsea

(If nonresident, give city or town and State)

Length of stay: In place of death 2 years 7 months 7 days. In place of residence 47 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 12, 1961, to July 1, 1961, 1961I last saw her alive on June 30, 1961, death is said to
have occurred on the date stated above, at 11:46 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive cardiac failureINTERVAL
BETWEEN
ONSET AND
DEATH1 dayDue To (b) Generalized arteriosclerosisseveral

Due To (c) _____

OTHER SIGNIFICANT CONDITIONS Diabetes MellitusseveralWas autopsy performed? noWhat test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? _____

If so, specify no(Signed) John F. Collins, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 27 Bennington Street, MaldenHoly Cross Rovers, Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL 5 July 19617 NAME OF FUNERAL DIRECTOR Walter S WalataADDRESS 125 Washington Ave ChelseaReceived and filed _____ 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

F

9 COLOR

White10 SINGLE (write the word)
MARRIED Married
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of _____

(Give maiden name of wife in full)

(or) WIFE of Walenty Nowicki

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 70 Years _____ Months _____ Days _____

If under 24 hours

_____ Hours _____ Minutes

13 Usual

Occupation: Housewife

(Kind of work done during most of working life)

14 Industry

or Business: At Home15 Social Security No. NONE16 BIRTHPLACE (City) Poland

(State or country)

17 NAME OF

FATHER Wawrzyn Pigulski

18 BIRTHPLACE OF

FATHER (City) Poland

(State or country)

19 MAIDEN NAME

OF MOTHER Jozefa Golon

20 BIRTHPLACE OF

MOTHER (City) Poland

(State or country)

21

Informant Walenty Nowicki(Address) 19 Medford St ChelseaI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



-RULES OF PRACTICE

JUL - 5 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

-THIS IS A
NENT RECORD.
se only

APPROVED
ink or black
writer ribbon.

INSTRUCTIONS
FOR
L CERTIFICATE

a giving
OF DEATH

not enter
than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
to the terminal
condition given

Chapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates.

HAP. 46, §§ 9 &

HAP. 114 §§ 45,

HAP. 38 § 6.)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Nursing Home

2 FULL NAME Mary Porter (Treasor)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 406 Broadway St. Malden
(Usual place of abode)

Length of stay: In place of death years months 21 days. In place of residence 4 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

I last saw h_____ alive on _____, 19____, death is said to

have occurred on the date stated above, at 5:05 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To (b) Arteriosclerotic Heart Disease years

Due To (c) Generalized Arteriosclerosis years

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Arthur C. Murray, M. D.

(Address) Winthrop Board of Health, 1 July 1961

6 Cambridge Cemetery, Cambridge
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 6 1961

7 NAME OF FUNERAL DIRECTOR William J. Killian
ADDRESS 1 Sprague St. Revere

Received and filed JUL 5 1961 19

(Registrar)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 129

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word).
MARRIED WIDOW
WIDOWED or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Ernest B. Porter
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 0 Months 4 Days If under 24 hours
Hours Minutes

13 Usual Occupation: House wife
(Kind of work done during most of working life)

14 Industry or Business: AT Home

15 Social Security No. NONE

16 BIRTHPLACE (City) BOSTON MASS
(State or country)

17 NAME OF FATHER unable to learn TREANOR

18 BIRTHPLACE OF FATHER (City) unable to learn
(State or country)

19 MAIDEN NAME OF MOTHER unable to learn

20 BIRTHPLACE OF MOTHER (City) unable to learn
(State or country)

21 Informant Mrs FANNIE VERGE
(Address) 405 BROADWAY MALDEN

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Calhoun
(Signature of Agent of Board of Health or other)

HO (Official Designation) July 3/61 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RECEIVED

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUL - 5 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 130

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Baby Boy Ham { (Was deceased a
(First Name) (Middle Name) (Last Name) U. S. War Veteran,
(If deceased is a married, widowed or divorced woman, give also maiden name.) if so specify WAR) NO.

(a) Residence, No. 86 Sargent Street, Winthrop St. 5 minutes
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days. 5

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 10 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
im 19..... to..... 19.....
I last saw him alive on July 10, 1961, death is said to
have occurred on the date stated above, at 2:39 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity - 23 weeks

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M. Traunstein Jr., M. D.

(PRINT OR TYPE SIGNATURE)

(Address) Winthrop Date 7/10/61

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 11, 1961

7 NAME OF FUNERAL DIRECTOR Arthur B. March

ADDRESS 174 Winthrop St Winthrop, Mass.

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED single
WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE.....Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: unemployed
(Kind of work done during most of working life)

14 Industry or Business: none

15 Social Security No. none

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

17 NAME OF FATHER Harold Addison Ham, Jr.

18 BIRTHPLACE OF FATHER (City) Winthrop
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Elizabeth Ann Tewksbury

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Massachusetts

21 Informant Harold A. Ham
(Address) 86 Sargent St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

July 11-1961
(Official Designation) (Date of Issue of Permit)

M R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
give rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

- Chapter 137,
f 1954, requires
ians to print or
the cause or
of death on
certificates, and
r 48, Acts of
requires Physi-
o print or type
under signature.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

RECEIVED The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.



Statement of Occupation.—Precise statement of occupation is very important so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUL 11 1961

SUFFOLK

The Commonwealth of Massachusetts



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 131

1 PLACE OF DEATH
(County)
WINTHROP
(City or Town)

19 Fairview St., Winthrop

No. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

DOMINIC P. IERARDO Ierardi

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

19 Fairview St., Winthrop

(a) Residence, No. (Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 10, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Acute myocardial infarction.

5 Accident, suicide, or homicide (specify) Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

(Address) Boston Date 7/10 61

7 Place of Burial, or Cremation Holy Cross Cemetery, Malden (City or Town)

DATE OF BURIAL July 13, 1961

8 NAME OF FUNERAL DIRECTOR Vincent Kapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed JUL 12 1961 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word) MARRIED WIDOWED or DIVORCED male white single

11a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 50 Years, Months, Days If under 24 hours Hours, Minutes

14 Usual Occupation Assistant District Engineer (Kind of work done during most of working life)

15 Industry or Business New England Power System

16 Social Security No. 011-16-7773

17 BIRTHPLACE (City) (State or country) Malden Mass.

18 NAME OF FATHER Philip Ierardi

19 BIRTHPLACE OF FATHER (City) (State or country) Italy

20 MAIDEN NAME OF MOTHER Carmela Kinaldi

21 BIRTHPLACE OF MOTHER (City) (State or country) Boston Mass.

22 Informant (Address) Carmela Ierardi (mother) 19 Fair View St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sisson Health officer (Official Designation) (Date of Issue of Permit) 7/12/61

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-6-60-928115

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

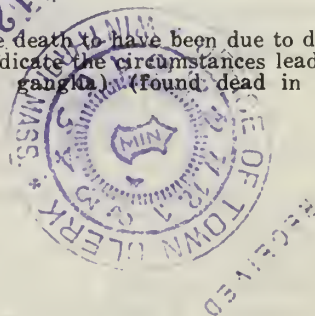
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death)."



JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.Suffolk
(County)Winthrop
(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 132

No. 142 Pleasant St. {If death occurred in a hospital or institution,
St. { give its NAME instead of street and number}

PHYSICIAN — IMPORTANT

2 FULL NAME Helena F. Harvey
(If deceased is a married, widowed or divorced woman, give also maiden name.)
{(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 30 Waldemar Ave St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 2 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 12, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 1, 1961, to July 12, 1961I last saw her alive on July 7, 1961, death is said to
have occurred on the date stated above, at 7:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

INTERVAL
BETWEEN
ONSET AND
DEATH

6 days

Due To Hypertension
(b)Several
yearsDue To
(c)OTHER
SIGNIFICANT Generalized arteriosclerosis
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F. Collins M.D.

John F. Collins, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 27 Bennington Street Date July 13, 1961

6 Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 15, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass

Received and filed JUL 14 1961 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Single
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: At Home
(Kind of work done during most of working life)14 Industry
or Business:

15 Social Security No.

16 BIRTHPLACE (City) Waltham
(State or country) Mass

17 NAME OF FATHER Charles J. Harvey

18 BIRTHPLACE OF FATHER (City) Waltham
(State or country) Mass

19 MAIDEN NAME OF MOTHER Ellen L. Lanagan

20 BIRTHPLACE OF MOTHER (City) Waltham
(State or country) Mass21 Informant Margaret Wilson
(Address) 30 Waldemar Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent or Board of Health or other

(Official Designation)

(Date of Issue of Permit)

M R-301A

PLACE OF DEATH

INSTRUCTIONS
FOR
CERTIFICATEn giving
E OF DEATHnot enter
e than one
se for each
, (b) and (c)does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which causedtions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
to print or type
nder signature.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

M R-301A

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 45 Atlantic St.

STANDARD
CERTIFICATE OF DEATH

Registered No. 133

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Michael J. Moynihan

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)INSTRUCTIONS
FOR
L CERTIFICATE(a) Residence, No. 45 Atlantic Street
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 12, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
July 5, 1961, to July 12, 1961.I last saw him alive on July 11, 1961, death is said to
have occurred on the date stated above, at 5:00 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO SCLEROTIC HEART
DISEASEDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSGENERALIZED ARTERIOSCLEROSIS 10 YRS.
HYPERTROPHIC ARTHRITIS 4 YRS.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL LABORATORY

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) M. Traumstein, M. D.

M. TRAUMSTEIN, JR., M.D.
(PRINT OR TYPE SIGNATURE)(Address) 73 BARTLETT RD. Date July 12, 1961
WINTHROP, MASS.6 Holy Cross Malden Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 15 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUL 14 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED10a If married, widowed or divorced
HUSBAND of Sarah Alexander
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 93 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Retired Clerk
(Kind of work done during most of working life)

14 Industry or Business: Am. Agriculture Corp

15 Social Security No. 032-01-4873

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER Timothy Moynihan

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Lynch

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Mary Moynihan
(Address) 45 Atlantic St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

H. O. [Signature] (Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

Suffolk
(County)

Winthrop
(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No. 134

No. Mayflower Rest Home

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Henry H Mc Laughlin

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 130 Grovers Ave
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years 6 months days In place of residence 38 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 13 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19 to 19

I last saw h. alive on 19 death is said to
have occurred on the date stated above, at 7:05 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To (b) Arteriosclerotic Heart Disease 10 yrs

Due To (c) Generalized Arteriosclerosis 20 yrs

OTHER SIGNIFICANT CONDITIONS Prostatism yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Arthur C. Murray M. D.

Arthur C. Murray M.D.
(PRINT OR TYPE SIGNATURE)

Winthrop Board of Health 13 July 61

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 15 1961 19

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed 19

JUL 14 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 8 Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Retired Gardener
(Kind of work done during most of working life)

14 Industry or Business: Landscaping

15 Social Security No. 022-16-7610

16 BIRTHPLACE (City) New York
(State or country) New York

17 NAME OF FATHER Henry E Mc Laughlin

18 BIRTHPLACE OF FATHER (City) Vermont
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Thompson

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Amy B Mc Laughlin
(Address) 64 Vinal Ave Somerville

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan
(Signature of Agent of Board of Health or other)

Ho and July 14 1961
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
se, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

Chapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

11. C.

6-59-925686

V.B.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



RECEIVED

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 40 Cutler

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 135

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Mover
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO.(a) Residence, No. 40 Cutler St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 20 years.....months.....days. In place of residence 25 years.....months.....days.

PRINT MEDICAL CERTIFICATE OF DEATH BLACK INK

3 DATE OF DEATH July 17, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
October 1940 to July 1961
I last saw her alive on July 16, 1961, death is said to
have occurred on the date stated above, at 7:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

(b) Cerebral Arteriosclerosis 5 yrs.

OTHER SIGNIFICANT CONDITIONS Parkinson's Syndrome 15 yrs.
Rheumatoid Arthritis 15 yrs.

Was autopsy performed? no

What test confirmed diagnosis Clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify(Signed) Charles Liberman M. D.
also print name Charles Liberman(PRINT OR TYPE SIGNATURE)
(Address) 203 Shore Drive, Date July 17, 1961Workmens Circle (Lebanon) West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 18, 1961

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline.

Received and filed JUL 17 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED married10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Jacob Mover
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Odessa, Russia
(State or country)

17 NAME OF FATHER Myer Abramhoff

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Mollie (unknown)

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Jacob Mover
(Address) 40 Cutler Street, Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

Suffolk

Winthrop

(City or Town)

No.

142 Pleasant Street *Winthrop Convalescent Home*STANDARD
CERTIFICATE OF DEATH

Registered No.

136

2 FULL NAME. Mary E Meehan (Welch)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 46 Washington Ave.
(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....7 days. In place of residence.....20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 18 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
May 26, 1949, to JULY 18, 1961
I last saw her alive on JULY 18, 1961, death is said to
have occurred on the date stated above, at 11:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA of COLON
AND GENERAL CARCINOMATOSISDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSARTERIO-SCLEROTIC HEART D.
ARTHRITIS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 142 PLEASANT ST. Date 7/18 1961

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 20 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed JUL 20 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)
MARRIED
WIDOWED Widow
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE

88 Years 8 Months 22 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

None

(Kind of work done during most of working life)

14 Industry

or Business:

At home

15 Social Security No.

None

16 BIRTHPLACE (City)
(State or country)

Chelsea

Mass

17 NAME OF
FATHER

John Welch

18 BIRTHPLACE OF
FATHER (City)

Unable to obtain

(State or country)

19 MAIDEN NAME

OF MOTHER

Annie -----

20 BIRTHPLACE OF
MOTHER (City)

Unable to obtain

(State or country)

PARENTS

21

Informant
(Address)

William Welch

30 Red Barn Rd. Wayland

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Serianus
(Signature of Agent of Board of Health or other)Health Officer
(Official Designation)7/19/61
(Date of Issue of Permit)

V.B.

M R-301A

INSTRUCTIONS
FOR
AL CERTIFICATEIn giving
E OF DEATHnot enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
i, etc. It means
eose, or compli-
which causeditions, if any,
s gave rise to
e cause (a),
g the under-
cause lost.nditions contrib-
o death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
o print or type
nder signature.

M.C.

-11-59-926662

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING..... JUL 20 1961 AM
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-301A

INSTRUCTIONS
FOR
VITAL CERTIFICATE

In giving
E OF DEATH

to not enter
more than one
cause for each
(a), (b) and (c)

does not mean
mode of dying,
heart failure,
a, etc. It means
cause, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
g the under-
cause last.

ditions contrib-
o death but not
to the terminal
condition given

- Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
requires Physi-
o print or type
nder signature.

-11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No. 137

No. Winthrop Community Hospital {If death occurred in a hospital or institution,
St. give its NAME instead of street and number}
2 FULL NAME Michael Joseph Murphy {If deceased is a married, widowed or divorced woman, give also maiden name.}
(a) Residence. No. 40 Bowdoin St. Winthrop - Mass
(Usual place of abode) (If nonresident, give city or town and State)
Length of stay: In place of death 0 years 0 months 17 days. In place of residence 35 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 20 1961
(Month) (Day) (Year)
4 I HEREBY CERTIFY That I attended deceased from July 3 1961 to July 20 1961
I last saw him alive on July 19 1961, death is said to have occurred on the date stated above, at 4:15 a.m.
DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Arterio sclerotic Heart Disease 10yr
Due To Generalized Arterio sclerosis 10yr
(b)
Due To Cerebral Hemorrhage 17 days
(c)
OTHER SIGNIFICANT CONDITIONS

INTERVAL
BETWEEN
ONSET AND
DEATH

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John F. Collins M.D.

(PRINT OR TYPE SIGNATURE)

(Address) John F. Collins MD 21 July 61

6 Holy Cross Maiden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 22 1961

7 NAME OF FUNERAL DIRECTOR Ernest Phlegman

ADDRESS 147 Winthrop St Winthrop

Received and filed 19

JUL 21 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Widowed
10a If married, widowed or divorced HUSBAND of Mary C. Crowley (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 years 1 Months 14 Days If under 24 hours Hours Minutes

13 Usual Occupation Retired Chauffeur (Kind of work done during most of working life)

14 Industry or Business Standard Oil Co

15 Social Security No. 108-03-1320

16 BIRTHPLACE (City) Milwaukee (State or country) Wisconsin

17 NAME OF FATHER Michael J. Murphy

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Helena V. Namey

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant William Murphy (Address) 40 Bowdoin St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Serianne (Signature of Agent or Board of Health or other)

H.O. 721/61 (Official Designation) (Date of Issue of Permit)

137

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....JUL 21 1961 AM
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years and over. If the occupation has been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)

Guardian Hospital 85 Otis St., Camb.

No.

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Cambridge

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 138

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}2 FULL NAME. Violet Thomas
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran. no
if so specify WAR.)(a) Residence. No. 26 Beacon St., Winthrop St. Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 20, 1961
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
July 14, 1961 to July 20, 1961
or July 19, 1961
I last saw him alive on July 19, 1961, death is said to
have occurred on the date stated above, at 9:35 A. m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Recurrent Subdural Hematoma

Due To Cerebral Atrophy
(b)

5 yrs.

Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Operation5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) Francis E. Smith, M.D. M. D.
(Address) 85 Otis St. Camb. Date July 20 61

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 29, 1961

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed July 20, 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Widowed
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
C.N.B.L.

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 54 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Home
(Kind of work done during most of working life)

14 Industry or Business: Housewife

15 Social Security No. C.N.B.L.

16 BIRTHPLACE (City) C.N.B.L.
(State or country)

17 NAME OF FATHER C. N.B.L.

18 BIRTHPLACE OF FATHER (City) C.N.B.L.
(State or country)

19 MAIDEN NAME OF MOTHER C.N.B.L.

20 BIRTHPLACE OF MOTHER (City) C.N.B.L.
(State or country)21 Informant Veterans Bureau
(Address) Winthrop, Mass.

A TRUE COPY Frederick W. Banks

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED July 20 1961

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

AUG - 9 1961 AM

PLACE OF DEATH

SUFFOLK

(County)

Winthrop

(City or Town)

No.

Winthrop Community Hospital

Baby Girl Bushey

2 FULL NAME.

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

INSTRUCTIONS
FOR
AL CERTIFICATEIn giving
E OF DEATHnot enter
than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
e, etc. It means
ease, or compli-
which causeditions, if any,
h gave rise to
e cause (a),
g the under-
cause last.ditions contrib-
o death but not
to the terminal
condition given- Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
r 48, Acts of
quires Physi-
o print or type
nder signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 139

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)INSTRUCTIONS
FOR
AL CERTIFICATEIn giving
E OF DEATHnot enter
than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
e, etc. It means
ease, or compli-
which causeditions, if any,
h gave rise to
e cause (a),
g the under-
cause last.ditions contrib-
o death but not
to the terminal
condition given- Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
r 48, Acts of
quires Physi-
o print or type
nder signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHJuly 21 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

July 21 1961, to July 21 1961

I last saw him alive on July 21 1961, death is said to

have occurred on the date stated above, at 5:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

Prematurity

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

At alectasis of lungs

Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A. Paul D. Hagopian, M. D.

A. PAUL D. HAGOPIAN
(PRINT OR TYPE SIGNATURE)

(Address) 39 QUARRY ARCH, SEA Date July 21 1961

6 MF BENEDICT, West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 24 1961

7 NAME OF

FUNERAL DIRECTOR

ADDRESS 20 The Green, Boston
JUL 25 1961

Received and filed19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

FEMALE

9 COLOR

White

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED single

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE.....Years.....Months.....Days

If under 24 hours

14 Hours.....Minutes

13 Usual

Occupation: (Kind of work done during most of working life)

14 Industry

or Business:

15 Social Security No.

16 BIRTHPLACE (City)
(State or country)

Winthrop

17 NAME OF
FATHER

George J. Bushey

18 BIRTHPLACE OF

FATHER (City)

Boston

(State or country)

19 MAIDEN NAME
OF MOTHERMARRIED
A. Hackett
Phildred Hackett

20 BIRTHPLACE OF

MOTHER (City)

East Peppowah

(State or country)

MASS

PARENTS

21 Informant

(Address)

George Bushey
1 Vahor Rd East BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

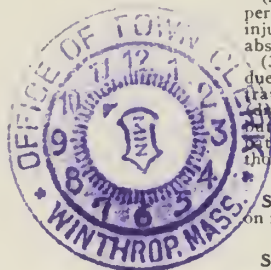
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical drugs or poisons) thermal, or electrical agents, and deaths following abortion, and also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL 25 1961

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

Registered No. 140

2 NAME OF FETUS (if given)

Baby Boy Titus

3 DATE OF DELIVERY July 24, 1961

(Month) (Day) (Year)

4 SEX ☒ Male ☐ Female ☐ Undetermined

5 COLOR (if determined) ☒ W

6 THIS BIRTH (Check one) ☒ Single ☐ Twin ☐ Triplet

7 IF MULTIPLE BIRTH, BORN: 1st 2nd 3rd

8 FULL NAME Victor Titus

9 RESIDENCE, NO. 88 Holyoke St., STREET CITY OR TOWN Malden STATE Mass.

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 42 (Years)

12 PLACE OF BIRTH Nova Scotia (City or Town) (State or country)

13 OCCUPATION Crane Operator

14 MAIDEN NAME Mary Doheney PRESENT NAME Mary Titus

15 RESIDENCE, NO. 88 Holyoke St., STREET CITY OR TOWN Malden STATE Mass.

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 42 (Years)

18 PLACE OF BIRTH Revere, Mass. (City or Town) (State or country)

19 INFORMANT Victor Titus

20 PREVIOUS DELIVERIES TO MOTHER (Do not include this fetus) 7 (a) How many children are now living? 7 (b) How many children were born alive but are now dead? 1 (c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY full term completed weeks 22 WEIGHT OF FETUS 5 (or Lb. Oz. Grams) 23 WHEN DID FETUS DIE? Before Labor ☒ During Labor or Delivery ☐ Unknown ☐ 24 AUTOPSY Yes ☐ No ☐

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cord around neck Asphyxia

Due To (b) Cord around neck

Due To (c) Cord around neck

OTHER SIGNIFICANT CONDITIONS none

26 Woodlawn Everett Place of Burial or Cremation (City or Town) DATE OF BURIAL July 25 1961

27 NAME OF FUNERAL DIRECTOR Howard S Reynolds ADDRESS Winthrop, Mass

Received and filed July 24, 1961

Registrar

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 12.21 a.m.

Signature of Attending Physician or Medical Examiner: Maurice Traunstein Jr. (PRINT OR TYPE SIGNATURE)

Address 73 Bartlett Rd, Winthrop Mass Date 7/24/61

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianine (Signature of Agent of Board of Health or other) 40. July 24, 1961 (Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

PLACE OF DEATH

Suffolk (County)

Winthrop (City or Town)

Winthrop Community Hospital

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 141

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Calisto Ramos
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, no
if so specify WAR)INSTRUCTIONS
FOR
L CERTIFICATE(a) Residence, No. 190 London St. East Boston Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....4.....days. In place of residence.....years.....months.....days.

n giving
OF DEATHnot enter
e than one
se for each
, (b) and (c)does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which causedions, if any,
give rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
of 1954, requires
cians to print or
the cause or
of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 25 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 21, 1961, to July 25, 1961
I last saw him alive on July 25, 1961, death is said to
have occurred on the date stated above, at 6:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute pulmonary edema

Due To
(b)

Congestive heart failure 4 days

Due To
(c)

Bilat. viral pneumonitis 5 days

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No clinical & X-ray

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Louis E. Schaffa M.D.
LOUIS E. SCHAFFA
(PRINT OR TYPE SIGNATURE)(Address) 19 Bennington St. Date 7-25-61
W. Boston Woodlawn Everett

6 Place of Burial or Cremation Woodlawn (City or Town) Everett

DATE OF BURIAL July 28, 1961

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed JUL 27 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED or DIVORCED10a If married, widowed, or divorced Ondina Nunes
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: machine operator
(Kind of work done during most of working life)

14 Industry or Business: Commercial Filters Corp.

15 Social Security No. 024-07-2195

16 BIRTHPLACE (City) (State or country) Portugal

17 NAME OF FATHER Michael Ramos

18 BIRTHPLACE OF FATHER (City) (State or country) Portugal

19 MAIDEN NAME OF MOTHER Elizabeth (unknown)

20 BIRTHPLACE OF MOTHER (City) (State or country) Portugal

21 Informant Ondina Ramos (wife)
(Address) 190 London St., East Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) Health Officer (Date of Issue of Permit) 7/26/61

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



JUL 27 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

Registered No. 142

1

PLACE OF DELIVERY

Suffolk
(County)
Winthrop
(City or Town)No. Winthrop Community Hospital
Baby Girl Marshall(If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS
(if given)3 DATE OF
DELIVERY7 / 27 / 61
(Month) (Day) (Year)4 SEX
Male... Female ☒ Undetermined5 COLOR (if
determined) W6 THIS BIRTH (Check one)
Single ☒ Twin Triplet7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd8
FULL
NAME

Leo Marshall

FATHER

9 RESIDENCE, NO. 50 Prescott St
CITY OR TOWN East Boston STATE Mass10 COLOR OF
RACE White11 AGE AT TIME OF
THIS DELIVERY 22 (Years)12 PLACE OF
BIRTH Boston Mass
(City or Town) (State or country)

13 OCCUPATION Truck Driver

14

MAIDEN NAME

Victoria Marshall

PRESENT NAME Victoria Marshall

15 RESIDENCE, NO. 50 Prescott St
CITY OR TOWN East Boston STATE Mass16 COLOR OF
RACE White17 AGE AT TIME OF
THIS DELIVERY 22 (Years)18 PLACE OF
BIRTH Lynn Mass
(City or Town) (State or country)

19 INFORMANT Victoria Marshall

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

2 normal

(a) How many children are
now living? 2(b) How many children were
born alive but are now
dead? None(c) How many previous fetal
deaths of ANY gestation
age? None21 LENGTH OF
PREGNANCY 32 completed weeks22 WEIGHT OF FETUS
(or Lb. 14 Oz. Grams)23 WHEN DID FETUS DIE?
Before Labor ☒ During Labor Unknown24 AUTOPSY
Yes No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Died in Utero

Due To (b) Erythroblastosis Fetalis

Due To (c) Rho Blood

OTHER SIGNIFICANT
CONDITIONS26 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 29, 1961

27 NAME OF
FUNERAL DIRECTOR Vincent Kapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed

JUL 28 1961

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 5:45 p.m., and product of conception was not a live birth.

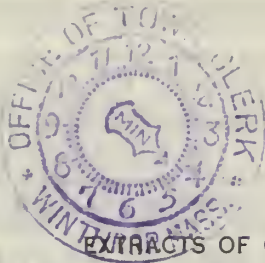
Signature of Attending Physician or Medical Examiner:

Louis E Schrafft M.D.

Louis E Schrafft
(PRINT OR TYPE SIGNATURE)

Address 19 Bennington Date July 27, 1961

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Schiavone
(Signature of Agent of Board of Health or other)H. O. 7/28/61
(Official Designation) (Date of Issue of Permit)In giving
CAUSE OF
FETAL DEATHdo not enter
more than one
cause for each
of (a), (b)
and (c)fetal or maternal
condition causing
fetal death (do
not use such
terms as stillbirth
or prematurity.)fetal and/or maternal
conditions,
any, which gave
rise to above
cause (a), stating
the underlying
cause last.conditions of fetus
mother which
have contributed
to fetal
death, but, in so
far as is known,
are not related
to cause given
(a).



FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.

ACTS OF 1960.

JUL 27 1961 PM

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

PLACE OF DEATH

Suffolk

(County)

Revere

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Revere

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 143

No. Grover Manor Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gertrude E. Graham (Steinauer)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 144 Hermon St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....month 10.....days. In place of residence 40.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 31, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from June 15, 1961, to July 31, 1961.
I last saw her alive on July 31, 1961, death is said to have occurred on the date stated above, at 3:00A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Brain Tumor

Due To
(b)Due To
(c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerosis

Was autopsy performed? No
What test confirmed diagnosis? X-Ray5 Was disease or injury in any way related to occupation of deceased? No
If so, specify ---

(Signed) George A. Haines M. D.

(Address) 16 Raymond St., July 31, 1961
Everett6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 2, 1961

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds
ADDRESS Winthrop, Mass.

Received and filed AUG 10 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Married or DIVORCED

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Gordon W. Graham (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 1 Months 26 Days If under 24 hours
Hours.....Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No.

16 BIRTHPLACE (City) Boston, Mass.
(State or country)17 NAME OF Charles Steinauer
FATHER18 BIRTHPLACE OF FATHER (City) Holland
(State or country)

19 MAIDEN NAME OF MOTHER Katherine Nold

20 BIRTHPLACE OF MOTHER (City) Pittsburgh, Penn.
(State or country)21 Informant Gordon W. Graham
(Address) 144 Hermon St., Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED August 1, 1961

143

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

AUG 10 1961 AM

ARIZONA STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

STATE FILE NO.

4368

CERTIFICATE OF DEATH

REGISTRAR'S NO.

808

BIRTH NO.		1. PLACE OF DEATH A. COUNTY Pima		B. LENGTH OF STAY IN THIS TOWN 6 wks IN ARIZONA 6 wks		2. USUAL RESIDENCE A. STATE Mass.		3. (WHERE DECEASED LIVED, IF INSTITUTION: RESIDENCE BEFORE ADMISSION) B. COUNTY Suffolk	
C. CITY OR TOWN Tucson		☐ IN CITY LIMITS ☐ OUTSIDE CITY LIMITS		C. CITY OR TOWN Winthrop		☐ IN CITY LIMITS ☐ OUTSIDE CITY LIMITS			
D. FULL NAME OF HOSPITAL OR INSTITUTION 1548 E Hedrick		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. STREET (IF RURAL, GIVE LOCATION) ADDRESS		E. IS RESIDENCE ON A FARM? YES ☐ NO ☐			
3. NAME OF DECEASED (TYPE OR PRINT) Helen Grant		A. (FIRST)		B. (MIDDLE)		C. (LAST) Cammall		4. SEX female	
5. COLOR OR RACE white		6A. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) widowed		7. DATE OF BIRTH MONTH DAY YEAR Jan. 28 1881		8. AGE (IN YEARS) LAST BIRTHDAY 80		9A. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF LIFE EVEN IF RETIRED) housewife	
9B. KIND OF BUSINESS OR INDUSTRY home		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		13. SOCIAL SECURITY NO. unknown	
14A. FATHER'S NAME unknown		14B. BIRTHPLACE (STATE OR COUNTRY) -		15A. MOTHER'S MAIDEN NAME unknown		15B. BIRTHPLACE (STATE OR COUNTRY) -			
16. INFORMANT'S SIGNATURE L. Smith		ADDRESS 1115 E. 1st St. Tucson		17. DATE OF DEATH (MONTH) (DAY) (YEAR) May 7 1961					
18. CAUSE OF DEATH ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), (C). THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHMA, ETC. IT MEANS THE DISEASE, INJURY, OR COMPLICATION WHICH CAUSED DEATH. PLACE DISEASE CONTRACTED, RELATING TO THE DISEASE OR CONDITION CAUSING DEATH.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) Cerebral thrombosis (B) art. sclerosis (C) - II. OTHER SIGNIFICANT CONDITIONS CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATING TO THE DISEASE OR CONDITION CAUSING DEATH.		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 6 weeks years					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☒					
21. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM ALIVE ON 4/13/61 AND THAT DEATH OCCURRED AT 6:57 A.M. FROM THE CAUSES AND ON THE DATE STATED ABOVE.		22A. SIGNATURE J. H. Hall		22B. ADDRESS 343 E. 1st St. Tucson		22C. DATE SIGNED 5-8-61			
23A. ACCIDENT (SPECIFY) SUICIDE HOMICIDE NATURAL CAUSE		23B. PLACE OF INJURY (E.G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)		23C. (CITY OR TOWN) (COUNTY) (STATE) Tucson Arizona					
23D. TIME (MONTH) (DAY) (YEAR) (HOUR) OF INJURY M		23E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		23F. HOW DID INJURY OCCUR?					
24A. CORONER'S SIGNATURE		24B. ADDRESS		24C. DATE SIGNED					
25A. BURIAL ☐ CREMATION ☒ REMOVAL ☐		25B. DATE May 9/61		25C. NAME OF CEMETERY OR CREMATORY Evergreen Crematorium		25D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Tucson, Arizona			
26A. DATE REC'D LOCAL REG. 5-10-61		26B. REGISTRAR'S SIGNATURE J. H. Hall		27A. FUNERAL DIRECTOR'S SIGNATURE Kerr Mortuary		27B. ADDRESS Tucson			
28A. EMBALMER'S SIGNATURE Deputy		28B. EMBALMER'S CERT NO. 226							

FORM VS-2 REV. 8-8-60 - 25

Received and filed

19

(Registrar of City or Town where death occurred)

(Registrar of City or Town where deceased resided)

DATE FILED

19

29, 1961

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON - THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

1

PLACE OF DEATH

Essex
(County)

Danvers
(City or Town)

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

The Commonwealth of Massachusetts



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. 145

2 FULL NAME Charles Planagan
(If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, no)

(a) Residence. No. 86 Plummer Avenue Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 3 months 19 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 25, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 6, 1959 to July 25, 1961
I last saw him on July 25, 1961 death is said to have occurred on the date stated above, at 5:50a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized Arteriosclerosis
years

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS ? Cancer Intestinal tract

Was autopsy performed? no
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Andrew Nichols III, M. D.

(Address) Hathorne, Mass. Date 7-25-1961

6 Holy Cross Cemetery, Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 27, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed AUG 15 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) WIDOWED

10a If married, widowed, or divorced HUSBAND of Lillian G. Fraser
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 8 Months 16 Days If under 24 hours Hours Minutes

13 Usual Occupation: Retired Fireman
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER Patrick Planagan

18 BIRTHPLACE OF FATHER (City) Unknown
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Elizabeth Martin

20 BIRTHPLACE OF MOTHER (City) Unknown
(State or country) Ireland

21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY Ronnie J. Toomey

ATTEST:
(Registrar of City or Town where death occurred)

DATE FILED July 31, 1961

RECEIVED



AUG 15 1961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

1

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

COPY OF

CERTIFICATE OF DEATH

Danvers

(City or Town making this return)

Registered No. 146

No. **Danvers State Hospital, Hathorne** If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME **William F. Crowley**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. **43 Loring Rd.**
(Usual place of abode) **Winthrop, Mass.**
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months **18** days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH August 1, 1961 (Month) (Day) (Year)	8 SEX male	9 COLOR white	10 SINGLE (write the word) married MARRIED WIDOWED OR DIVORCED
4 I HEREBY CERTIFY. That I attended deceased from July 14, 1961 to August 1, 1961 I last saw him alive on August 1, 1961 death is said to have occurred on the date stated above, at 4:10a.m.	10a If married, widowed, or divorced Gertrude Walsh HUSBAND of (Give maiden name of wife in full)		
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage	(or) WIFE of (Husband's name in full)		
Due To (b) Generalized Arteriosclerosis years	11 IF STILLBORN, enter that fact here.		
Due To (c) Diabetes Mellitus years	12 AGE 72 Years 6 Months 13 Days If under 24 hours Hours Minutes		
OTHER SIGNIFICANT CONDITIONS	13 Usual Occupation: Retired Engineer (Kind of work done during most of working life)		
Was autopsy performed? no What test confirmed diagnosis? Clinical & Laboratory	14 Industry or Business: 014-18-8818		
5 Was disease or injury in any way related to occupation of deceased? If so, specify	15 Social Security No. Boston		
(Signed) Andrew Nichols III M. D. (Address) Hathorne, Mass. 8-1-61	16 BIRTHPLACE (City) Mass. (State or country)		
6 Winthrop Cemetery, Winthrop, Mass. Place of Burial or Cremation (City or Town) DATE OF BURIAL August 3, 1961	17 NAME OF FATHER William Crowley		
7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc. ADDRESS E. Boston, Mass.	18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.		
Received and filed AUG 15 1961 (Registrar of City or Town where deceased resided)	19 MAIDEN NAME OF MOTHER Mary E. Clinton		
	20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.		
	21 Informant (Address) Mary E. Sheehan Hathorne, Mass.		
	A TRUE COPY Ronnie J. Toomey		
	ATTEST: (Registrar of City or Town where death occurred)		
	DATE FILED August 4, 1961		

RECEIVED



AUG 15 1961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. Winthrop Community Hospital

STANDARD CERTIFICATE OF DEATH

Registered No. 147

2 FULL NAME Marion Agnes Shea
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 5 Sagamore Ave.
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....11 days. In place of residence 50 years.....months.....days.

INSTRUCTIONS
FOR
AL CERTIFICATE

In giving
E OF DEATH

not enter
re than one
se for each
, (b) and (c)

does not mean
ode of dying,
s heart failure,
a, etc. It means
ease, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
g the under-
cause last.

nditions contrib-
to death but not
to the terminal
condition given

- Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
o print or type
nder signature.

A.C.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUG 1 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb 56 to AUG 1 1961

I last saw h alive on AUG 1 1961, death is said to
have occurred on the date stated above, at 205 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PULMONARY EMBOLUS

INTERVAL
BETWEEN
ONSET AND
DEATH
15 HRS

Due To (b) FRACTURE LEFT FEMUR

11 DAYS

Due To (c)

OTHER SIGNIFICANT CONDITIONS GENERAL ARTERIOSCLEROSIS

3 YRS

Was autopsy performed? No

What test confirmed diagnosis? X-ray - operation

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 222 PLEASANT ST Date 8/1 61

6 CALVARY BOSTON
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG 4 1961

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed AUG 3 - 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED SINGLE

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: OFFICE CLERK
(Kind of work done during most of working life)

14 Industry or Business: COURT HOUSE

15 Social Security No.

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

17 NAME OF FATHER JEREMIAH A SHEA

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER MARY A (SHEA)

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS

21 Informant HENRY J MULLEN
(Address) 105 WAREFIELD ST READING

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lixian
(Signature of Agent of Board of Health or other)

Health Office 8/3/61
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

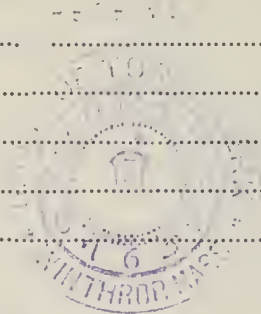
DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



AUG - 31 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, (c), (1), (2).)

25M-9-56-918227

PLACE OF DEATH

Middlesex
(County)
Somerville
(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Somerville
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 430148

Central Hospital-Central

No.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Mary F. McCusker (Boyle)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 51 Birch Road St. Winthrop, Mass.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. - years. - months 14 days. In place of residence. 3 years. - months. - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 8, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
August 5, 1961, to August 8, 1961

I last saw her alive on August 7, 1961, death is said to
have occurred on the date stated above, at 1:50A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart
disease decompensated

Due To Arteriosclerosis
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Israel Marcus, M. D.
192 School St. Somerville, Mass. Date Aug. 8, 1961
(Address)

6 Cambridge Cem., Cambridge, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 11, 1961

7 NAME OF FUNERAL DIRECTOR John F. Donahue
ADDRESS 66 Magazine St. Cambridge, Mass

Received and filed. 19.

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
Thomas J. McCusker
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years. - Months. - Days If under 24 hours
Hours. Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. - - - - -
16 BIRTHPLACE (City) Cambridge, Mass
(State or country)

17 NAME OF FATHER Patrick S. Boyle

18 BIRTHPLACE OF FATHER (City) Boston, Mass
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Hughes

20 BIRTHPLACE OF MOTHER (City) Boston, Mass
(State or country)

21 Informant Mrs. Jane Gillies (Sister)
(Address) 51 Birch Rd. Winthrop, Mass.

A TRUE COPY William J. Donahue
ATTEST: (Registrar of City or Town where death occurred)

Aug. 9 61
DATE FILED 19.

TX

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

RM R-301A

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

Registered No. 149

PHYSICIAN — IMPORTANT

2 FULL NAME Charles Davis Tuckerman

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)INSTRUCTIONS
FOR
AL CERTIFICATE(a) Residence. No. 24 Perkins Street
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months...11 days. In place of residence. 45 years.....months.....days.

In giving
E OF DEATHdo not enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
a, etc. It means
ease, or compli-
which causeditions, if any,
a gave rise to
e cause (a),
g the under-
cause last.ditions contrib-
to death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
nder signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug. 10, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
March 16, 1961 to Aug. 10, 1961
I last saw him live on Aug. 10, 1961 death is said to
have occurred on the date stated above at 12:30 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH
5 mos.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Pancreas.

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSCoronary Artery
Heart Disease

4 yrs.

Was autopsy performed?

No

What test confirmed diagnosis? Surgical, Pathological

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed)

Charles Liberman

(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 8/10/1961

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 12, 1961

7 NAME OF
FUNERAL DIRECTOR

Alfred B. Marsh

ADDRESS 174 Winthrop Street, Winthrop, Mass.

Received and filed AUG 14 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED married
WIDOWED
or DIVORCED

male

white

10a If married, widowed, or divorced
HUSBAND of Anne Phyllis Jordan
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years. 8 Months. 25 Days
If under 24 hours
.....Hours.....Minutes13 Usual Occupation: salesman
(Kind of work done during most of working life)

14 Industry or Business: wholesale oil equipment

15 Social Security No. 021-03-7517

16 BIRTHPLACE (City) Wakefield
(State or country) Massachusetts

17 NAME OF FATHER Albert William Tuckerman

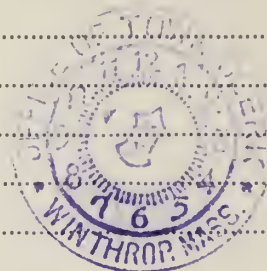
18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Massachusetts19 MAIDEN NAME Dennison
OF MOTHER Rebecca Josephine20 BIRTHPLACE OF MOTHER (City) Brooklyn
(State or country) New York21 Informant Mrs. Charles D. Tuckerman
(Address) 24 Perkins St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer 8/10/61
(Official Designation) (Date of Issue of Permit)

11-59-926662

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

AUG 14 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

PLACE OF DEATH

Middlesex
(County)Carlisle
(City or Town)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 151

No. Sunny Nook Nursing Home

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lucy (Hall) Greenlaw

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence, No. 25 Chester Ave.
(Usual place of abode)St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 2 months 14 days. In place of residence 45 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 12 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 1961 to Aug. 1961

I last saw her alive on Aug. 11 1961, death is said to

have occurred on the date stated above, at 9:40 A.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

INTERVAL
BETWEEN
ONSET AND
DEATH

1 da.

Due To Generalized arterio-
(b) sclerosis

years

Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Donald S. Barber, M. D.

(Address) Billerica, Mass. Aug. 13 1961

6 Mt. Pleasant Cemetery Sudbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 15 1961

7 NAME OF FUNERAL DIRECTOR Edmund H. Tunnicliffe
ADDRESS Concord, Mass.

Received and filed 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Widowed or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William P. Greenlaw
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 92 Years 4 Months 0 Days If under 24 hours
Hours Minutes13 Usual Occupation: At Home
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Gloucester
(State or country) Mass.

17 NAME OF FATHER Allen J. Hall

18 BIRTHPLACE OF FATHER (City) Pownal
(State or country) Vermont

19 MAIDEN NAME OF MOTHER Sarah Andrews

20 BIRTHPLACE OF MOTHER (City) Hillsboro
(State or country) New Hampshire21 Informant Robert Hall
(Address) 289 Boston Post Rd., Sudbury

A TRUE COPY

ATTEST: Margaret M. Heald
(Registrar of City or Town where death occurred)

DATE FILED August 13 1961

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

151

STANDARD
CERTIFICATE OF DEATH

Registered No. _____

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. P 5 BEAL ST. WINTHROP St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME WILFRED LOUIS MERCIER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence. No. P 5 BEAL ST WINTHROP St. (If nonresident, give city or town and State)
(Usual place of abode)Length of stay: In place of death _____ years _____ months _____ days. In place of residence 2 years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 15 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov. 59 to August 15 1961
I last saw him alive on August 15 1961, death is said to
have occurred on the date stated above, at 7:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral HemorrhageDue To Hypertension
(b)Due To Left Hemiplegia
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NoWhat test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____(Signed) Charles Lebrun M. D.(Address) Winthrop Mass Date 8/17/19616 Holy Cross Malden Mass.
Place of Burial or Cremation (City or Town)DATE OF BURIAL August 18 19617 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS 210 Winthrop St. WinthropReceived and filed AUG 17 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED MARRIED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of JOSEPHINE MARY MURPHY
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 62 Years _____ Months _____ Days _____
If under 24 hours
Hours _____ Minutes _____13 Usual Occupation: SHIPPING
(Kind of work done during most of working life)14 Industry or Business: SHOE FACTORY15 Social Security No. 028-10-675016 BIRTHPLACE (City) HAVERHILL
(State or country) MASS.17 NAME OF FATHER EDWARD MERCIER18 BIRTHPLACE OF FATHER (City) CANADA
(State or country)19 MAIDEN NAME OF MOTHER ERNESTINE HOULE20 BIRTHPLACE OF MOTHER (City) CANADA
(State or country)21 Informant (Address) Josephine M. Mercier
P 5 Beal St WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other)
Ralph E. Lynam
Health Officer 8/17/61
(Official Designation) (Date of Issue of Permit)

1 R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
se, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates.

100M-11-55-916145

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and four-
teen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is required.
- (3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. 152

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. 133 Cliff Avenue{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Wallace Linwood Fabyan

(First Name)

(Middle Name)

(Last Name)

{(Was deceased a
{ U. S. War Veteran,
{ if so specify WAR) W.W.1.(a) Residence No. 133 Cliff Avenue
(Usual place of abode)St. _____
(If nonresident, give city or town and State)Length of stay: In place of death 17 years..... months..... days. In place of residence 17 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 16 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
AUG. 11, 1954, to AUG 16, 1961
I last saw him live on 8/14, 1961, death is said to
have occurred on the date stated above, at 1:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF PANCREAS
WITH OBSTRUCTIVE JAUNDICE 8 mo.(b) HYPERTENSIVE HEART &
VASCULAR DISEASE
(c) POLYCYTHEMIA
OSTEO ARTHRITIS
DIABETES MELLITUS - SECONDARY
TO (a) & (b)OTHER SIGNIFICANT CONDITIONS
DIABETES MELLITUS - SECONDARY
TO (a) & (b)Was autopsy performed? NoWhat test confirmed diagnosis? CLINICAL & X-RAY5 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)(Address) 222 Pleasant St. Date 8/16, 1961
WINTHROP, MASS.6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)DATE OF BURIAL August 18, 19617 NAME OF FUNERAL DIRECTOR Clifford B. MarshADDRESS 174 Winthrop St. Winthrop, Mass.Received and filed AUG 17 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
or DIVORCED10a If married, widowed or divorced,
HUSBAND of Ruth Waldron
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 years..... 4 Months..... 7 Days
If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Glass contractor
(Kind of work done during most of working life)14 Industry or Business: own business15 Social Security No. 012-05-024016 BIRTHPLACE (City) Pittsfield
(State or country) Massachusetts17 NAME OF FATHER Daniel E. Fabyan18 BIRTHPLACE OF FATHER (City) Buxton
(State or country) Maine19 MAIDEN NAME OF MOTHER Mildred Horton20 BIRTHPLACE OF MOTHER (City) Savoy
(State or country) Massachusetts21 Informant Mrs. Wallace J. Fabyan
(Address) 133 Cliff Ave, Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other) Heath Officer(Official Designation) Heath Officer (Date of Issue of Permit) 8/17/61

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedons, if any,
have rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
ans to print or
ne cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
der signature.

928145

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

AUG 17 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 153

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 19 Myrtle Ave.

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ellen Barron
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 19 Myrtle Ave
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 21, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from April, 1961 to Aug. 21, 1961
I last saw her alive on Aug. 17, 1961, death is said to have occurred on the date stated above, at 11:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease

(b) Arteriosclerotic Heart Disease C.X.

Due To
(c)INTERVAL
BETWEEN
ONSET AND
DEATH

3 yrs

OTHER SIGNIFICANT CONDITIONS Cardiac Decompensation 6 mos.
Cardiac Decompensation

Was autopsy performed?

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Charles Liberman, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop Mass. Date 8/21/61

6 Holy Cross Cemetery Malden Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL August 24, 19617 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass

Received and filed AUG 23 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Thomas E. Barron
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Ireland
(State or country)

17 NAME OF FATHER Edward O'Brien

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Carroll

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Helen Barron
(Address) 19 Myrtle Ave., Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Liberman
(Signature of Agent of Board of Health or other Health Officer)
(Official Designation) 8/23/61
(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
the, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
the terminal
condition givenChapter 137,
95A, requires
is to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

-59-925686

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

AUG 23 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD

CERTIFICATE OF DEATH

Registered No. 151

Suffolk

(County)

Winthrop

(City or Town)



No. Mt. Convalescent Home

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME. ROSSINE MACK (McGroch)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 157 Park St.

St. Chelsea, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 2 years.....months.....days. In place of residence 18 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST 22 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JUNE 6, 1949, to AUG 22, 1961, 1949.

I last saw her alive on AUG 22, 1961, death is said to have occurred on the date stated above, at 8:48 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO SCLEROTIC HEART DISEASE

INTERVAL
BETWEEN
ONSET AND
DEATH

5 YRS

Due To (b) GENERALIZED ARTERIO SCLEROSIS

5 YRS

Due To (c)

OTHER SIGNIFICANT CONDITIONS CHRONIC NEPHRITIS

1 YR

Was autopsy performed?

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) William P. Finnegan M. D.

(Address) 647 Broadway Date 8-22-1961

6 St. Philips Cen. (Crompton R. I.)
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 25, 1961

7 NAME OF FUNERAL DIRECTOR Edmund J. Carafa

ADDRESS 389 Washington Ave., Chel.

Received and filed AUG 24 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Harry B. Mack (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 7 Months 3 Days If under 24 hours Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: --

15 Social Security No. --

16 BIRTHPLACE (City) Patterson, New Jersey (State or country)

17 NAME OF FATHER John McGroch

18 BIRTHPLACE OF FATHER (City) Scotland (State or country)

19 MAIDEN NAME OF MOTHER Rossine Fitzsimmons

20 BIRTHPLACE OF MOTHER (City) Scotland (State or country)

21 Informant (Address) 100 Quincy Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 8/24/61

100M-11-55-916145

EXTRACTS
FROM THE LAWS OF
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteenth, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.Suffolk
(County)Winthrop
(City or Town)Mount's Convalescent Home
No. 104 Highland AveSTANDARD
CERTIFICATE OF DEATH

Registered No. 155

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)2 FULL NAME Ellen E. Hurley
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 83 Loring Road
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months 11 days. In place of residence. 50 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 26, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Aug. 14, 1961, to Aug. 26, 1961I last saw her alive on Aug. 31, 1961, death is said to
have occurred on the date stated above, at 1:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ~~Cerebral~~ Arteriosclerotic
Heart Disease

(b) Cardiac Decompensation 4 wks

Due To (c)

OTHER SIGNIFICANT CONDITIONS Fracture Rt. Hip. 2 mos.

Was autopsy performed? No

What test confirmed diagnosis Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles Liberman, M. D.

Charles Liberman
(PRINT OR TYPE SIGNATURE)

Winthrop Board of Health 8-26-1961

6 Holy Cross Malden, Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 29, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed AUG 29 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Single10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 96 Years..... Months..... Days If under 24 hours
Hours..... Minutes13 Usual Occupation: Retired Milliner
(Kind of work done during most of working life)

14 Industry or Business: Millinery

15 Social Security No. None

16 BIRTHPLACE (City) Boston Mass
(State or country)

17 NAME OF FATHER Jeremiah Hurley

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Annie Barret

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Charles Blais
(Address) 83 Loring Road WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Liberman
(Signature of Agent of Board of Health or other)Health Officer 8/25/61
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
re, or compli-
which causedons, if any,
give rise to
cause (a),
the under-
cause lost.ditions contrib-
death but not
the terminal
condition given

m.c.

Chapter 137,
95A, requires
ns to print or
cause or
f death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

A-59-925686

Medical Examiner Notified

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE AUG 29 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Rest Home

STANDARD
CERTIFICATE OF DEATH

Registered No. 156

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

2 FULL NAME

SARAH GREENE

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence, No.
(Usual place of abode)

40 Trident Avenue

St.

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months 10 days In place of residence 12 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 27 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov. 1956 to August 27, 1961I last saw her alive on August 26, 1961, death is said to
have occurred on the date stated above, at 12:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular Occlusion

Left Hemiplegia

(b) Arteriosclerosis, cerebral

Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Diabetes Mellitus

INTERVAL
BETWEEN
ONSET AND
DEATH

2 wks.

6 wks.

8 yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed)

Charles Liberman, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 8/27/1961

6 Anshe Poland Cong. Cem., Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 28, 1961

7 NAME OF FUNERAL DIRECTOR B. SCHLOSSBERG & SONS

ADDRESS 1257 Blue Hill Ave., Mattapan

Received and filed AUG 29 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
OR DIVORCED

10a If married, widowed, or divorced

HUSBAND of Myer Greene (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years..... Months..... Days If under 24 hours
Hours..... Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. none

16 BIRTHPLACE (City) Poland
(State or country)

17 NAME OF FATHER Abraham Segal

18 BIRTHPLACE OF FATHER (City) Poland
(State or country)

19 MAIDEN NAME OF MOTHER Rachael c.n.b.l.

20 BIRTHPLACE OF MOTHER (City) Poland
(State or country)21 Informant Nathan Green
(Address) 40 Trident Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Liberman
(Signature of Agent of Board of Health or other)Health Officer
(Official Designation)8/28/61
(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
e for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
se, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.itions contrib-
death but not
the terminal
condition givenChapter 137,
954, requires
ns to print or
e cause or
f death on
ificates, and
48, Acts of
quires Physi-
print or type
ler signature.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

AUG 29 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
VITAL CERTIFICATEn giving
E OF DEATHnot enter
e than one
se for each
, (b) and (c)does not mean
ode of dying,
heart failure,
, etc. It means
case, or compli-
which causedtions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
ne cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Daniel Canney
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 186 Winthrop St
(Usual place of abode){(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

Length of stay: In place of death.....years. 1 months.....days. In place of residence. 47 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 29 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 28 1961, to Aug 29 1961
I last saw him alive on Aug 28 1961, death is said to
have occurred on the date stated above, at 6:47 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

(b) Due To arterio sclerosis -
generalized

(c) Due To

OTHER SIGNIFICANT CONDITIONS emphysema

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Gregorie, M. D.

(PRINT OR TYPE SIGNATURE) Joseph GREGORIE

(Address) 194 Washington Ave Date 8/29 1961

6 Winthrop Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 31 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed AUG 30 1961 19

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 157

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED10a If married, widowed or divorced
HUSBAND of Elizabeth Turnbull
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: Retired R.R. Mail Clerk
(Kind of work done during most of working life)

14 Industry or Business: Railway Mail

15 Social Security No. 015-20-4628

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER Michael Canney

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Margaret

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Elizabeth Canney
(Address) 186 Winthrop St WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sericani
(Signature of Agent of Board of Health or other)Health Office 8/30/61
(Official Designation) (Date of Issue of Permit)

111 V

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. **158**

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. **95 Marshall**{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **ANITA MARIA MULONE (CAMMARATA)**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, **no**
if so specify WAR)(a) Residence. No. **95 Marshall**
(Usual place of abode)St. **Winthrop**
(If nonresident, give city or town and State)Length of stay: In place of death **45** years.....months.....days. In place of residence **45** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **August 29, 1961**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at **12:30am**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Death ensued at 12:30 Am.**(b) **August 29, 1961 - Death presumably****due to hypertension and**(c) **chronic nephritis. Duration**OTHER SIGNIFICANT CONDITIONS **1 1/2 years.**Was autopsy performed? **no**What test confirmed diagnosis? **For Winthrop**

5 Was disease or injury in any way related to occupation of deceased?

(Signed) **Charles Liberman M.D.**
(PRINT OR TYPE SIGNATURE)(Address) **Winthrop** Date **8/29/1961**6 **Winthrop Cemetery, Winthrop**
Place of Burial or Cremation (City or Town)DATE OF BURIAL **Sept. 1, 1961**7 NAME OF FUNERAL DIRECTOR **Ernest P. Caggiano**
ADDRESS **147 Winthrop St., Winthrop**Received and filed **SEP 1 1961**

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED **married**10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)(or) WIFE of **Anthony Mulone**
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **73** Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: **Housewife**
(Kind of work done during most of working life)14 Industry or Business: **at home**

15 Social Security No.

16 BIRTHPLACE (City)
(State or country) **Italy**17 NAME OF FATHER **Francesco Cammarata**18 BIRTHPLACE OF FATHER (City)
(State or country) **Italy**19 MAIDEN NAME OF MOTHER **Marianna Palermo**20 BIRTHPLACE OF MOTHER (City)
(State or country) **Italy**21 Informant **Anthony Mulone**
(Address) **95 Marshall St., Winthrop**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

Official Designation

(Date of Issue of Permit)

(Registrar)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedns, if any,
ave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
dition given

A. C.

Chapter 137,
54, requires
s to print or
cause or
death on
ificates, and
8, Acts of
quires Physi-
print or type
er signature.

1-59-926662

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

SEP --1 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Suffolk

(County)

Winthrop

(City or Town)

124 River Road

No.

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 159

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary E (MacNiven) Jones
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 124 River Road

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 62 years.....months.....days. In place of residence 60 years.....months.....days.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)oes not mean
e. of dying,
heart failure,
etc. It means
se, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.itions contrib-
death but not
to the terminal
condition givenChapter 137,
95A, requires
ns to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
r signature.

C.

11-59-926662

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 31 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Sept 1960, 19, to August 31, 1961I last saw her alive on Aug 29, 1961 death is said to
have occurred on the date stated above, at 1:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure

Due To (b) arteriosclerotic heart disease byrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS Senility

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Harold B. Greenfield, M. D.

Harold B. Greenfield
(PRINT OR TYPE SIGNATURE)

(Address) 117 S. Key St. Winthrop, Mass. Aug 31

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 2 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed SEP 5 1981

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widow10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
John L Jones
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 9 23
Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) New York City
(State or country) New York

17 NAME OF FATHER John MacNiven

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Sarah Morrison

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant Elsie Jones
(Address) 124 River Road WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Suranney
(Signature of Agent of Board of Health or other)Health Office 9/1/61
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

SEP - 5 1951

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

only cause of death Dr. was able to give this office. jd.

PLACE OF DEATH

SUFFOLK
(County)BOSTON
(City or Town)

No. NEW ENGLAND HOSPITAL

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME

JEAN (CORSAO) D'AMICO

(If deceased is a married, widowed or divorced woman, give also maiden name.)

Registered No. 05597

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence, No.

71 GROVERS AVE

St.

WINTHROP MASS

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....2.....days. In place of residence 3.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

6

7

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

6/5

19.6/1

to

6/7

1961

I last saw him alive on

6/7

1961, death is said to

have occurred on the date stated above, at 6 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

TOXIC SHOCK

INTERVAL
BETWEEN
ONSET AND
DEATHDue To
(b)

SEPTICEMIA

Due To
(c)POST ABDOMINAL SURGERY
Abdominal adhesions.OTHER
SIGNIFICANT
CONDITIONS

Suspension of Vagina.

Was autopsy performed? No

What test confirmed diagnosis? Y3

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Time Taken M.D.

M. D.

P. PARETORDEY M.D.

(PRINT OR TYPE SIGNATURE)

(Address) NEW ENGLAND HOSPITAL 6/8 1961

6

ST. MICHAEL'S BOSTON

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

JUNE 12,

1961

7 NAME OF

FUNERAL DIRECTOR

DIPIETROK VAZZA

ADDRESS

11 HENRY ST. EAST BOSTON

Received and filed

JUN 19 1961

Charles A. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

FEMALE WHITE

MARRIED WIDOWED OR DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of ADOLPHE D'AMICO

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 54 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

BRUSHER

(Kind of work done during most of working life)

14 Industry

or Business

MEN'S CLOTHING FACTORY

15 Social Security No.

021-24-7742

16 BIRTHPLACE (City)

(State or country)

BOSTON

MASS.

17 NAME OF

FATHER

VINCENTO CORSAO

18 BIRTHPLACE OF

FATHER (City)

(State or country)

ITALY

19 MAIDEN NAME

OF MOTHER

ANNA DELLEA

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

ITALY

21

Informant

(Address)

ADOLPHE D'AMICO JR.

93 BEAKSHIRE AVE. SOUTHWICK

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Daniel J. McNamee

(Signature of Agent of Board of Health or other)

2445

6/19/61

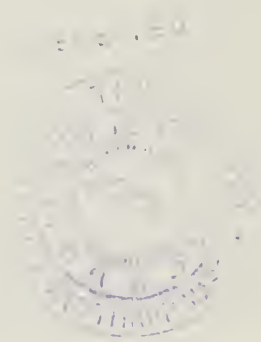
(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



SEP 25 1961 AM

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL

Cora

2 FULL NAME Ella C. Lent

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 55 Sargent Street Winthrop, Massachusetts

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....2.....months.....days. In place of residence.....45.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 12, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from April 14, 1961, to June 12, 1961

I last saw her alive on June 12, 1961, death is said to

have occurred on the date stated above, at 4:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) EXSANGUINATION

INTERVAL
BETWEEN
ONSET AND
DEATH
days

Due To (b) DUODENAL ULCERS, BLEEDING

6 days

Due To (c)

OTHER SIGNIFICANT CONDITIONS CARCINOMA OF BREAST, RECURRENT

20 yrs

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Carol L. Cley, M.D.

Carol L. Cley, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date June 12, 1961

6 Woodlawn Cemetery, Everett, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL June 15, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed JUN 16 1961

Charles A. Mackie

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permits
with Board of Health
or its Agent.

Registered No. 115220

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

female white

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of John Israel Lent

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 85 Years 1 Months 7 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

housework

(Kind of work done during most of working life)

14 Industry

or Business:

own home

15 Social Security No.

012-03-3977-D.

16 BIRTHPLACE (City)

(State or country)

East Boston

Massachusetts

17 NAME OF

FATHER

William C. Peters

18 BIRTHPLACE OF

FATHER (City)

East Boston

(State or country)

Massachusetts

19 MAIDEN NAME

OF MOTHER

Sarah Frances Hammond

20 BIRTHPLACE OF

MOTHER (City)

East Boston

(State or country)

Massachusetts

21

Informant

(Address)

Miss. Dorothy M. Lent

55 Sargent St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mass. J. Daniels

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie
City Registrar



SEP 25 1961 AM

1

Received and filed JUN 16 1961
Charles H. Inackie
(Registrar)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



SEP 25 1961 AM

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 163

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 39 Pico Avenue

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Katherine McGillicuddy

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 39 Pico Avenue

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months..... days. In place of residence 48 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 1, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
2/14, 19.61, to 9/1, 19.61
I last saw her alive on 9/1, 19.61, death is said to
have occurred on the date stated above, at 7 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Due To BRONCHIO-
(b) PNEUMONIA
(c) Due To CARCINOMA
OF LUNG.INTERVAL
BETWEEN
ONSET AND
DEATH20 DAYS
6 MO.OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? 0
What test confirmed diagnosis? XRAY - BIOPSY5 Was disease or injury in any way related to occupation of deceased? 0
If so, specify(Signed) Fred O'Peghan, M. D.
FRED O'PEGHAN M.D.
PRINT OR TYPE SIGNATURE
(Address) 113 PLEASANT, Date 9/1, 19.61
WINTHROP6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 5, 19.61

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed SEP 1 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Single
or DIVORCED10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 48 Years..... Months..... Days If under 24 hours
..... Hours..... Minutes13 Usual Occupation: Operator
(Kind of work done during most of working life)

14 Industry or Business: Telephone

15 Social Security No.

16 BIRTHPLACE (City) Winthrop
(State or country) Mass

17 NAME OF FATHER William McGillicuddy

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Mary A. Harron

20 BIRTHPLACE OF MOTHER (City) Everett
(State or country) Mass21 Informant Nancy McGillicuddy
(Address) 39 Pico Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 9/1/61

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedms, if any,
ave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
condition given

C.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....SEP - 1961 PH.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. WINTHROP CONVALESCENT HOME

STANDARD
CERTIFICATE OF DEATH

Registered No. 161

If death occurred in a hospital or institution,
give its NAME instead of street and number

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO2 FULL NAME FRANCESCA MANGONE
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 68 FALCON
(Usual place of abode)St. EAST BOSTON, MASS.
(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. 16 days. In place of residence 2 years. months. days.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedons, if any,
have rise to
cause (a),
the under-
cause last.itions contrib-
death but not
the terminal
condition givenChapter 137,
954, requires
ns to print or
e cause or
e of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT. 6, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JAN - 8, 1948, to SEPT. 6, 1961
I last saw alive on SEPT. 6, 1961, death is said to
have occurred on the date stated above, at 2:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION

INTERVAL
BETWEEN
ONSET AND
DEATH
2 DAYSDue To (b) ARTERIOSCLEROTIC
HEART DISEASE

10 YRS.

Due To
(c)OTHER SIGNIFICANT
CONDITIONS LEFT CEREBRAL HEMORRHAGE 1 MONTH
PARKINSON'S DISEASE 15 YRS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify NO

(Signed) A. N. Caplan M. D.

A. N. CAPLAN M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 186 PRINCETON ST. E. B. Date 9-6-1961

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT. 9, 1961

7 NAME OF FUNERAL DIRECTOR DIPIETROK VAZZA
ADDRESS 11 HENRY ST. EAST BOSTON

Received and filed SEP 8 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of BENJAMIN MANGONE
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) ITALY
(State or country)

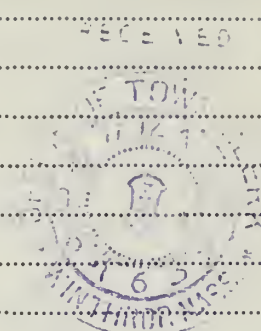
17 NAME OF FATHER RICCI

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER NOT LEARNED

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)21 Informant (Address) AUGUSTUS MANGONE
68 FALCON ST. EAST BOSTONI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
Health Officer 9/8/61
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 165

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

WINTHROP CONVALESCENT HOME

If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME CONCETTA RIVOIRE
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 74 ARCADIA St. REVERE MASS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years 3 months 3 days. In place of residence 8 years 3 months 3 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept 7 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct 11 1960, to Sept 7 1961
I last saw her alive on Sept 7 1961, death is said to
have occurred on the date stated above, at 1:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

INTERVAL
BETWEEN
ONSET AND
DEATH

2 mths

Due To (b) Generalized Arteriosclerosis 5 years

Due To (c) DIABETES Mellitus 10 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO.

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Morris J. Sacks M. D.
MORRIS J. SACKS M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 45 Shilley Ave. Date Sept 7 1961

6 FOREST HILLS BOSTON
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT. 11 1961

7 NAME OF FUNERAL DIRECTOR DIPIETROVALZA
ADDRESS 111 HENRY ST EAST BOSTON

Received and filed SEP 8 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of LAMY RIVOIRE
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years 7 Months 3 Days
If under 24 hours Hours Minutes

13 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. 028-03-7857

16 BIRTHPLACE (City) ITALY
(State or country)

17 NAME OF FATHER SALVATORE CASSIANI

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER ANNA LA CIVITA

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant (Address) TINA LUCEY
74 ARCADIA ST, REVERE

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 9/8/61

R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
(b) and (c)

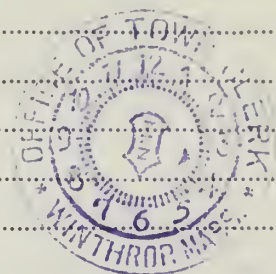
es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which caused

ns, if any,
ave rise to
cause (a),
the under-
cause last.

tions contrib-
death but not
the terminal
condition given

Chapter 137,
954, requires
s to print or
cause or
f death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

SPACE FOR ADDITIONAL INFORMATION RECEIVED
 DATE OF ENTERING MILITARY SERVICE
 DATE OF DISCHARGE
 RANK, RATING
 ORGANIZATION AND OUTFIT
 SERVICE NUMBER



SEP - 8 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 166

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 12 Cherry Street

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME William Walton Sterndale

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.(a) Residence, No. 12 Cherry Street
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, 19 years, months, days. In place of residence, 19 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 7, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
June 8, 1961, to September 7, 1961
I last saw him alive on September 7, 1961, death is said to
have occurred on the date stated above, at 6:50 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH
3 mos.DEATH WAS CAUSED BY: IMMEDIATE CAUSE
bronchogenic carcinoma right
(a) lungDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS noneWas autopsy performed? no
What test confirmed diagnosis? Clinical & Laboratory5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein, Jr., M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Date Sept. 8, 1961

Winthrop 52, Mass.

6 Elmwood Cemetery Methuen, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 11, 1961

7 NAME OF
FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed 7-8-61 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED or DIVORCED10a If married, widowed, or divorced,
HUSBAND of Teresa Gilmartin
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years 2 Months 0 Days If under 24 hours
Hours Minutes13 Usual Occupation wool grader
(Kind of work done during most of working life)

14 Industry or Business: wholesale wool sales

15 Social Security No. 025-07-9330

16 BIRTHPLACE (City) Lancaster
(State or country) England

17 NAME OF FATHER John James Sterndale

18 BIRTHPLACE OF FATHER (City) Lancaster
(State or country) England

19 MAIDEN NAME OF MOTHER Jane Elizabeth Walton

20 BIRTHPLACE OF MOTHER (City) Lancaster
(State or country) England21 Informant Mrs. William W. Sterndale
(Address) 12 Cherry St. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

R-301A

DUCTIONS
OR
CERTIFICATEgiving
OF DEATHot enter
than one
for each
b) and (c)es not mean
of dying,
near failure,
tc. It means
or, compli-
which causedns, if any,
ave rise to
ause (a),
the under-
ause last.ions contrib-
eath but not
the terminal
dition given

C.

Chapter 137,
1954, requires
ans to print or
the cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

928145

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

14

R-301A

CTIONS
FOR
CERTIFICATE

giving
OF DEATH

ot enter
than one
for each
b) and (c)

es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which caused

ns, if any,
ave rise to
cause (a),
the under-
cause last.

ions contrib-
death but not
the terminal
dition given

Chapter 137,
1954, requires
ns to print or
ie cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

STANDARD
CERTIFICATE OF DEATH

Registered No. 167

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Esther L. Cohen (Nee Nagarya)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence, No. 280 River Road
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT 10 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
JAN 1955 to SEPT 10 1961
I last saw her alive on SEPT 10 1961, death is said to
have occurred on the date stated above, at 12:5A m.

INTERVAL
BETWEEN
ONSET AND
DEATH
14 DAYS

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) UREMIA - 2 DAYS
CEREBRAL VASCULAR ACCT

Due To (b) HYPERTENSION and

Due To (c) HYPERTENSIVE HEART DIS

10YRS

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 222 Pleasant St. WINTHROP MASS Date 9/10 1961

6 Sharon Memorial Park- Sharon
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 10, 1961

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service, Inc

ADDRESS 1615 Beacon St. Brookline

Received and filed SEPT 11, 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Married
WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Myer Cohen (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 23 Days If under 24 hours
Hours Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business: Housewife

15 Social Security No. none

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Nagarya, Jacob

18 BIRTHPLACE OF FATHER (City) Poland
(State or country) Europe

19 MAIDEN NAME OF MOTHER Fannie (c.b.l.)

20 BIRTHPLACE OF MOTHER (City) Poland
(State or country) Europe

21 Informant (Address) Gerald N. Cohen,
3 Wauwinet Road, Newton, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
Health Officer 9/10/61
(Official Designation) (Date of Issue of Permit)

928145

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 168

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. Bayview Nursing Home (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Carrie E. Weston
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 36 Ingleside Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 12 years.....months.....days. In place of residence 35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 10 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
January 16, 1949, to September 10, 1961.

I last saw him alive on September 9, 1961, death is said to
have occurred on the date stated above, at 1:30 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CONGESTIVE HEART FAILURE

Due To
(b) ARTERIOCLEROTIC HEART DISEASE 54 YRS

Due To
(c) ARTERIOSCLEROSIS AND HYPERTENSION 12 YRS

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed) Dorothy Cheney Appleton, M. D.
DOROTHY CHENEY APPLETON
(PRINT OR TYPE SIGNATURE)

(Address) 197 Woodside Ave. Sept 10 19 61
Winthrop, Mass.

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 12, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed SEP 12 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED single
WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 0 Months 21 Days If under 24 hours
Hours Minutes

13 Usual Occupation: housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

17 NAME OF FATHER Washburn Weston

18 BIRTHPLACE OF FATHER (City) Duxbury
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Hannah Hawkins

20 BIRTHPLACE OF MOTHER (City) Boonton
(State or country) New Jersey

21 Informant Washburn Weston, Jr.
(Address) Schenectady, New York

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or permit was issued:

Mass. Ralph C. Lynam
(Signature of Agent of Board of Health or other)

Health Officer SEP 12 1961
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
(b) and (c)

es not mean
of dying,
heart failure,
etc. It means
the under-
cause last.

ns, if any,
ave rise to
cause (a),
the under-
cause last.

tions contrib-
death but not
the terminal
condition given

Chapter 137,
1954, requires
ans to print or
the cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS
 MEDICAL EXAMINER'S
 CERTIFICATE OF DEATH

To be filed for burial permit
 with Board of Health
 or its Agent.

Registered No. 159

19 Nevada Street, Winthrop

No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME IRMA RUBIN
 (First Name) (Middle Name) (Last Name)
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
 (Was deceased a U. S. War Veteran, if so specify WAR) NO

19 Nevada Street, Winthrop

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode)

Length of stay: In place of death 45 years months days. In place of residence 45 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 12, 1961
 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
 Occlusive arteriosclerosis of coronary arteries.

5 Accident, suicide, or homicide (specify) _____
 Date and hour of injury _____ 19____
 IF ACCIDENTAL, was injury causally related to the death? _____
 Where did injury occur? _____
 (City or town and State)
 Did injury occur in or about home, on farm, in industrial place, or in public place? _____
 (Specify type of place)
 Manner of Injury _____
 (How did injury occur?)
 Nature of Injury _____
 While at work? _____ Was autopsy performed? Yes.

6 Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Michael A. Luongo, M.D.
 (Print or Type Signature)
 (Address) Boston Date 9/12 61

7 Ohel Jacob, Woburn
 Place of Burial, or Cremation, (City or Town)
 DATE OF BURIAL September 13, 19 61

8 NAME OF FUNERAL DIRECTOR Arnold Golov
 ADDRESS 1668 Beacon St. Brookline

Received and filed SEP 13 1961 19____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)
 Female White MARRIED WIDOWED or DIVORCED Single

11a If married, widowed, or divorced HUSBAND of _____
 (Give maiden name of wife in full)

(or) WIFE of _____
 (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 44 Years 11 Months 22 Days If under 24 hours Hours Minutes

14 Usual Occupation: State Employed
 (Kind of work done during most of working life)

15 Industry or Business: Division of Emp. Security

16 Social Security No. _____

17 BIRTHPLACE (City) East Boston
 (State or country)

18 NAME OF FATHER Dr. Maurice S. Rubin

19 BIRTHPLACE OF FATHER (City) Russia
 (State or country)

20 MAIDEN NAME OF MOTHER Celia Markell

21 BIRTHPLACE OF MOTHER (City) Russia
 (State or country)

22 Informant Dr. Maurice S. Rubin
 (Address) 19 Nevada St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 9/13/61

IN B-WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-6-60-92811.5



If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death)."

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
condition given

01, C.

Chapter 137,
1954, requires
ans to print or
re cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 170

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Convalescent Home

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Catherine McCarthy

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a

U. S. War Veteran,

{if so specify WAR) NO

(a) Residence, No. 18 Plummer Avenue

(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 2 months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 14 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Feb 1 1960 to Sept 14 1961

I last saw him alive on 9/14 1961, death is said to

have occurred on the date stated above, at 1:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHO-PNEUMONIA

Due To ARTERIO SCLEROTIC

(b) HEART DISEASE

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? 0

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? 0

If so, specify

(Signed) Fred O'Regan, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 113 Pleasant St. Date 9/15-1961

WINTHROP

6 Aspen Grove Cemetery Ware, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Sept. 16, 1961

7 NAME OF
FUNERAL DIRECTOR

Cedric B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed

SEP 15 1961

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

female white

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Albert Justin McCarthy

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 34 Years 0 Months 8 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

housework

(Kind of work done during most of working life)

14 Industry

or Business:

own home

15 Social Security No.

024-01-9876-B

16 BIRTHPLACE (City)

(State or country)

Burnt Isle

Scotland

17 NAME OF
FATHER

Robert Farquhar

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Burnt Isle

Scotland

19 MAIDEN NAME

OF MOTHER

Mary Stuart

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Scotland

21

Informant

(Address)

John McCarthy

18 Plummer Ave, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

9/15/61

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

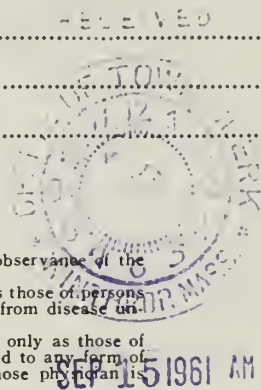
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 171

PLACE OF DEATH

SUFFOLK
(County)
WINTHROP
(City or Town)



No. 56 SHIRLEY ST.

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)}

2 FULL NAME FRANCIS WILLIAM IRWIN
(First Name) (Middle Name) (Last Name)

PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran,
if so specify WAR) WW II

(a) Residence, No. 56 SHIRLEY ST.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 15 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT 17 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at 477 11:30 A.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death was presumably
(b) due to natural causes
(c) probably coronary occlusion.

OTHER SIGNIFICANT CONDITIONS Wintthrop Board of Health
Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles Liberman, M.D.
Charles Liberman, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Wintthrop Date 9/18/1961

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT 20 1961

7 NAME OF FUNERAL DIRECTOR JOHN T. WHITE SR.

ADDRESS 135 LONDON ST. EAST BOSTON

Received and filed SEP 19 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED MARRIED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of CECILIA DONAHUE
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 55 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: INSURANCE BROKER
(Kind of work done during most of working life)

14 Industry or Business: RETIRED

15 Social Security No. 028-20-7415

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS.

17 NAME OF FATHER WILLIAM IRWIN

18 BIRTHPLACE OF FATHER (City) EAST BOSTON
(State or country) MASS.

19 MAIDEN NAME OF MOTHER JULIA DORGAN

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS.

21 Informant CECILIA V. IRWIN (WIFE)
(Address) 56 SHIRLEY ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
Health Officer 9/18/61
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
b) and (c)

es not mean
of dying,
near failure,
tc. It means
or compli-
which caused

ns, if any,
ve rise to
ause (a),
he under-
ause last.

ions contrib-
path but not
the terminal
dition given

Chapter 137,
954, requires
ns to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

28145

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 11-3-42

DATE OF DISCHARGE..... 12-19-42

RANK, RATING..... SK. 2C

ORGANIZATION AND OUTFIT..... U. S. NAVY

SERVICE NUMBER..... 203-71-84

RECEIVED



SEP 19 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
e, or compli-
which caused

ns, if any,
have rise to
cause (a),
the under-
cause last.

tions contrib-
death but not
the terminal
condition given

Chapter 137,
1954, requires
ns to print or
ne cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Emma L. Hughes (Thurston)

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 97 Woodside Ave., Winthrop Mass

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 11 days. In place of residence, 38 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 20, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1961, to Sept 20, 1961

I last saw her alive on Sept 20, 1961, death is said to have occurred on the date stated above, at 1.30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Antero-septal Myocardial

infarction 11 days

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Electrocardiogram

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Dorothy Cheney Appleton, M.D.

DOROTHY CHENEY APPLETON
(PRINT OR TYPE SIGNATURE)

(Address) 197 Woodside Ave. Date Sept 20, 1961

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 23, 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass,

Received and filed 19

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 172

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)}

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED Wid

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Richard O Hughes

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 1 Months 11 Days

If under 24 hours
Hours Minutes

13 Usual Occupation: House Wife

(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF

FATHER George Thurston

18 BIRTHPLACE OF

FATHER (City) Uxbridge

(State or country) Mass,

19 MAIDEN NAME

OF MOTHER Lizzie Andrews

20 BIRTHPLACE OF

MOTHER (City) Boston

(State or country) Mass

21 Informant Dorothy E Hughes

(Address) 97 Woodside Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED
SEP 23 1907
U.S. DEPT. OF THE INTERIOR
BUREAU OF LANDS
WASHINGTON, D.C.
RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury. --

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
e, or compli-
which caused

ns, if any,
ave rise to
ause (a),
the under-
ause last.

ians contrib-
death but not
the terminal
ndition given

Chapter 137,
54, requires
s to print or
cause or
f death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 173

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 21 Sea Foam Ave

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME ISADORE HOFFMAN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence. No. 21 Sea Foam Ave

(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 24 years months days. In place of residence 24 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 21, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Dec. 27, 1960, to Sept. 21, 1961I last saw him alive on Sept. 20, 1961, death is said to
have occurred on the date stated above, at 5:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive cerebral hemorrhage

INTERVAL
BETWEEN
ONSET AND
DEATH
1 hr.

Due To Cerebral arteriosclerosis

(b) 1 1/2 yrs

Due To Generalized arteriosclerosis

(c) 5 yrs

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus

5 yrs

Was autopsy performed? no

What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein, Jr., M.D.

M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Date Sept. 21, 1961

6 LIBERTY PROGRESSIVE EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 22 1961

7 NAME OF FUNERAL DIRECTOR TREF Funerals (Service Inc.)
ADDRESS 151 Washington Ave Chelsea

Received and filed 19.

SEP 22 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX m 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED widowed
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Rose Shaffer
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: M.T.A. Retained
(Kind of work done during most of working life)

14 Industry or Business: Maintenance

15 Social Security No. 024-10-4148

16 BIRTHPLACE (City) Austria
(State or country)

17 NAME OF FATHER DAVID

18 BIRTHPLACE OF FATHER (City) Austria
(State or country)

19 MAIDEN NAME OF MOTHER Leah (CIBL)

20 BIRTHPLACE OF MOTHER (City) Austria
(State or country)21 Informant Benjamin Hoffman
(Address) 121 Sea Foam Ave WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph S. Krumm
(Signature of Agent of Board of Health or other)HIO
(Official Designation)9/22/61
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 174

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Benjamin Ruskin
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence, No. 159 Locust St
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months..... days. In place of residence..... years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 21 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
June 1960 to Sept. 21 1961
I last saw him alive on Sept. 21 1961, death is said to
have occurred on the date stated above, at 7:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer Left Kidney

INTERVAL
BETWEEN
ONSET AND
DEATH
16 monthsDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

None

Was autopsy performed? No
What test confirmed diagnosis Clinical and Pathological.5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M.D.

(PRINT OR TYPE SIGNATURE)
(Address) Winthrop, Mass. Date 9/21/19616 Beth El W. Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 24 1961

7 NAME OF FUNERAL DIRECTOR TARE Funeral Service Inc.

ADDRESS 151 Washington Ave Chelsea

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED, WIDOWED, MARRIED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Eleanor Bates
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 68 Years..... Months..... Days If under 24 hours
Hours..... Minutes13 Usual Occupation: Shoe Mgr. RB?
(Kind of work done during most of working life)

14 Industry or Business: Shoes

15 Social Security No. 765?

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Abraham Ruskin

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Mrs. E. E. Ruskin
(Address) 159 Locust St WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

H.O. (Official Designation)

(Date of Issue of Permit) Sept. 21 - 1961

R-301A

DUCTIONS
FOR
CERTIFICATEgiving
OF DEATHot enter
than one
for each
b) and (c)es not mean
of dying,
heart failure,
etc. It means
or compli-
which causedms, if any,
ave rise to
ause (a),
the under-
ause last.ians contrib-
eath but not
the terminal
dition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
der signature.

928145

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED
SEP 12 1961 AM
HINTON, MASS.
RULES OF PRACTICE

The fulfillment of the purpose of these laws, calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 175

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Mary E. (GIBBONS)

Snyder

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 953 Shirley St.,
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death. years months 10 days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 21 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Sept 11 1961, to Sept 21 1961, 19I last saw her alive on Sept. 21 1961, death is said to
have occurred on the date stated above, at 11.15 Am.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Cerebral Thrombosis

Due To
(b)

Arteriosclerosis

10 days
5 yearsDue To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Dorothy Cherry Appleton M. D.
DOROTHY CHERRY APPLETON
(PRINT OR TYPE SIGNATURE)(Address) 197 Woodside Ave. Date Sept 21 1961
Winthrop, Mass6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT. 23 1961

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP MASS.

Received and filed SEP 22 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED
WIDOWED WIDOWED
or DIVORCED

FEMALE

WHITE

10a If married, widowed, or divorced
HUSBAND of(or) WIFE of JOHN A SNYDER
(Give maiden name of wife in full)
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 78 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: TEL OPERATOR
(Kind of work done during most of working life)

14 Industry

or Business: NEW ENGLAND TEL CO

15 Social Security No.

568-36-2664

16 BIRTHPLACE (City)

(State or country)

EAST BOSTON MASS

17 NAME OF FATHER DENNIS H GIBBONS

18 BIRTHPLACE OF

FATHER (City)

(State or country)

19 MAIDEN NAME

OF MOTHER HELEN (ONLY MOTHER)

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

21

Informant
(Address)NATALIE M. SNYDER
953 SHIRLEY ST WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

H. O. [Signature] SEP 22/61

(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedns, if any,
ave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
dition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
ler signature.

928145

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

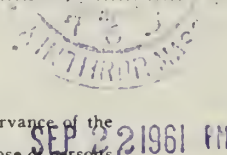
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 126

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 169 MAIN ST

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOHN J. MOYNIHAN

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence, No. 169 MAIN ST

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 35 years.....months.....days. In place of residence 35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept 25 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
1961 to 1961
I last saw him alive on Sept 24 1961, death is said to
have occurred on the date stated above, at 7:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

Due To (b) Hypertension Myocardial Infarction
(c) Tenative Heart Disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? Clinical Exam + EKG.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Louis E. Schaffner, M. D.

(Print or Type Name)

(Address) 1918 Beacon St. Date Sept 27 1961

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT. 28 1961

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY

ADDRESS WINTHROP

Received and filed SEP 27 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed or divorced
HUSBAND of ADELE NEVAPAS
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH

13 AGE 57 Years.....Months.....Days If under 24 hours
Hours.....Minutes

14 Usual Occupation: BAR TENDER
(Kind of work done during most of working life)

15 Industry or Business: LIQUOR

16 Social Security No. 023-12-4584

17 BIRTHPLACE (City) BOSTON
(State or country) MASS

18 NAME OF FATHER FRANCIS MOYNIHAN

19 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS

20 MAIDEN NAME OF MOTHER CATHERINE DEADY

21 BIRTHPLACE OF MOTHER (City) ST JOHN'S
(State or country) N.B.

22 Informant ADELE MOYNIHAN
(Address) 169 MAIN ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 9/27/61

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town in which the death should be transmitted on Form R-302 to the clerk of the city or town in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

COPY OF

CERTIFICATE OF DEATH

Cambridge

(City or Town making this return)

Registered No. 1342

No. Guardian Hospital, Cambridge St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME. Joseph Lanstein (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence. No. 42 Lewis Avenue St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years 10 months 10 days. In place of residence 10 years 10 months 10 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 27, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1961, to Sept. 28, 1961. I last saw him alive on Sept. 27, 1961, death is said to have occurred on the date stated above, at 9:15 pm

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia 4 days

Due To (b) Left Cerebellar Infarction

Due To (c) Severe Cardio-Vascular Disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Henry S. Robinson, M. D.

(Address) 363 Washington St., Somerville, Mass. Date 9/28/61

6 Mt. Lebanon-Zwiller, West Roxbury (City or Town)

DATE OF BURIAL September 28, 1961

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach

ADDRESS 10 Washington St., Dorchester, Mass.

Received and filed Oct. 6, 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCE Married

10a If married, widowed, or divorced HUSBAND of Leah Kramer (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Cooper (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Russia

17 NAME OF FATHER Samuel Lanstein

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Gittel - Cannot be learned

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Ruby Gordon (Address) 42 Lewis Ave., Winthrop, Mass.

A TRUE COPY Frederick H. Burke

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Sept. 28, 1961

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

Middlesex

(County)

Cambridge

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

COPY OF

CERTIFICATE OF DEATH

Cambridge

(City or Town making this return)

177

No. Guardian Hospital, Cambridge St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)Registered No. 13122 FULL NAME Joseph Lanstein
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR.

No

(a) Residence. No. 42 Lewis Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death.....years.....months 10 days. In place of residence.....10rs.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 27, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Sept. 16 1961, to Sept. 28 1961
I last saw him alive on Sept. 27 1961, death is said tohave occurred on the date stated above, at 9:15 pmINTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia4 daysDue To (b) Left Cerebellar InfarctionDue To (c) Severe Cardio-Vascular Disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Henry S. Robinson M. D.
363 Washington St., Somerville, Mass. Date 9/28/616 Mt. Lebanon-Zwiler, West Roxbury
Place of Burial or Cremation (City or Town)DATE OF BURIAL September 28 19617 NAME OF FUNERAL DIRECTOR Benjamin Blirnbach
ADDRESS 10 Washington St., Dorchester Mass.Received and filed OCT. 6 1961 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9. COLOR White 10 SINGLE (write the word) MARRIED
or WIDOWED or DIVORCED Married10a If married, widowed, or divorced
HUSBAND of Leah Kramer
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 75 AGE.....Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Cooper
(Kind of work done during most of working life)14 Industry or Business: Retired

15 Social Security No.

16 BIRTHPLACE (City) Russia
(State or country)17 NAME OF FATHER Samuel Lanstein18 BIRTHPLACE OF FATHER (City) Russia
(State or country)19 MAIDEN NAME OF MOTHER Gittel - Cannot be learned20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant (Address) Ruby Gordon
42 Lewis Ave., Winthrop, Mass.A TRUE COPY
ATTEST: Frederick H. Burke
(Registrar of City or Town where death occurred)DATE FILED Sept. 28, 1961 19

184



address
Washington Ave

M R-301A

INSTRUCTIONS
FOR
DEATH CERTIFICATE

not enter
more than one
cause for each
(b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
cation, which caused

conditions, if any,
gave rise to
cause (a),
the under-
cause lost.

conditions contrib-
uted to death but not
to the terminal
condition given

Chapter 137,
1954, requires
physicians to print or
type cause or
mode of death on
certificates, and
§ 48, Acts of
1954, requires Physi-
cians to print or type
their signature.

P 29 1961

11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

No. **Mayflower Nurseries Home**

STANDARD CERTIFICATE OF DEATH

Registered No. **128**

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN - IMPORTANT

2 FULL NAME **Richard L Enman**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) **No**}

(a) Residence. No. **39 Grovers Ave.**

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years **3** months.....days. In place of residence.....years **3** months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Sept 28 1961**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
DEC 24 1954 to **SEPT 28 1961**
I last saw him alive on **9/20 1961**, death is said to
have occurred on the date stated above, at **520 A** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **CEREBRAL ARTERIOSCLEROSIS
WITH HEMIPARESIS - RIGHT
AND PERIPHERAL ARTERIOSCLEROSIS**

Due To **WITH GANGRENE LEFT GREAT TOE**

Due To **GENERAL ARTERIOSCLEROSIS AND
(c) ARTERIO-SCLEROTIC HEART DISEASE**

OTHER SIGNIFICANT CONDITIONS **PROSTATIC HYPERTROPHY WITH
OBSTRUCTION**

Was autopsy performed? **No**

What test confirmed diagnosis? **CLINICAL**

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify

(Signed) **Myron N. King**, M. D.

MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) **222 Pleasant St Winthrop** Date **9/29 1961**

6 **Forest Hills Boston Mass**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Oct 2 1961**

7 NAME OF FUNERAL DIRECTOR **Ernest P Caggiano**

ADDRESS **147 Winthrop St Winthrop**

Received and filed19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED **Wid**
or DIVORCED

10a If married, widowed or divorced, give name of
HUSBAND of **Edna Kite**
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **81** Years **9** Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: **Retired Saleman**
(Kind of work done during most of working life)

14 Industry or Business: **Sporting Goods.**

15 Social Security No. **031-09-1362 B**

16 BIRTHPLACE (City) **Quebec**
(State or country) **Canada**

17 NAME OF FATHER **Philip Enman**

18 BIRTHPLACE OF FATHER (City)
(State or country) **Canada**

19 MAIDEN NAME OF MOTHER **Amanda ?**

20 BIRTHPLACE OF MOTHER (City)
(State or country) **Canada**

21 Informant **Old Age Agent**
(Address) **Town Hall Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Hermann
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) **Feb 29/61**

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 19 1961

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 179

PLACE OF DEATH

SUFFOLK (County)

WINTHROP (City or Town)

No. WINTHROP CONVALESCENT HOME

The death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME SWANBURG WILLIAM, A.
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN - IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No.
(Usual place of abode)

BROADWAY, Chelsea

(If nonresident, give city or town and State)

Length of stay: In place of death 3 years. months. days. In place of residence To years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT 29 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JULY 1958 to SEPT 29 1961
I last saw him alive on 9/29 1961, death is said to
have occurred on the date stated above, at 10:02 P. M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) NEPHRO SCLEROSIS AND
ARTERIO-SCLEROTIC HEART DIS 3 YRS.

Due To (b) GENERAL ARTERIO-SCLEROSIS 3 YRS.

Due To (c)

OTHER SIGNIFICANT CONDITIONS Congestive HEART FAILURE 2 DAYS.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.

MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 222 PLEASANT ST WINTHROP 9/29 1961

6 Woodhawn Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT. 2, 1961 19

7 NAME OF FUNERAL DIRECTOR W. R. CARAFIA

ADDRESS 389 WASHINGTON ST Chelsea

Received and filed OCT 8 1961 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (Write the word)
MARRIED WIDOWED or DIVORCED Single10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 years 2 months 29 days If under 24 hours
Hours Minutes13 Usual Occupation: Laborer retired
(Kind of work done during most of working life)

14 Industry or Business: Industry

15 Social Security No. none

16 BIRTHPLACE (City) Shelburne
(State or country) Nova Scotia

17 NAME OF FATHER UNKNOWN

18 BIRTHPLACE OF FATHER (City) Wales
(State or country) England

19 MAIDEN NAME OF MOTHER Cathrine Lewis

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant Mrs. Bessie Swana
(Address) 84 Green St WeymouthI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Official Designation Health Officer (Date of Issue of Permit) 10/2/61

(Registrar)

R-301A

DUCTIONS
FOR
CERTIFICATEgiving
OF DEATHot enter
than one
for each
(b) and (c)es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedns, if any,
ave rise to
ause (a),
the under-
ause last.ions contrib-
death but not
the terminal
dition givenChapter 137,
54, requires
s to print or
cause or
death on
ificates, and
8, Acts of
ures Physi-
rint or type
er signature.

59-925686

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 420

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Rhoda E (Woodward) Kimberly
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 198 Somerset Avenue St. Winthrop 52, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 2 months 25 days. In place of residence 45 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 30, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 27, 1955 to Sept. 30, 1961I last saw her alive on Sept. 30, 1961, death is said to
have occurred on the date stated above, at 11:50 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

INTERVAL
BETWEEN
ONSET AND
DEATH
12 wks

Due To (b) Coronary sclerosis 5 yrs.

Due To (c) Arteriosclerotic & hypertensive heart disease 8 yrs.

OTHER SIGNIFICANT CONDITIONS Generalized arteriosclerosis & hypertrophic arthritis 10 yrs.

Was autopsy performed? no

What test confirmed diagnosis? Clinical & laboratory

5 Was disease, or injury in any way related to occupation of deceased? No
If so, specify(Signed) M. Traunstein, Jr., M.D. M. D.
(PRINT OR TYPE SIGNATURE)(Address) 73 Bartlett Rd. Date Sept. 30, 1961
Winthrop 52, Mass.6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 3 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed OCT 2 - 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Married
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Gilead Kimberly
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 11 Months 25 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 019-26-6107

16 BIRTHPLACE (City) England
(State or country)

17 NAME OF FATHER Robert Woodawrd

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Tyers

20 BIRTHPLACE OF MOTHER (City) England
(State or country)21 Informant Gilead Kimberly
(Address) 198 Somerset Ave WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 10/2/61

R-301A

DUCTIONS
FOR
CERTIFICATEgiving
OF DEATHot enter
than one
for each
(b) and (c)es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which causedns, if any,
ave rise to
cause (a),
the under-
ause last.ions contrib-
death but not
the terminal
dition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
ler signature.

528145

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



RULES OF PRACTICE

OCT 21 1961 PM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

San Diego

(County)

San Diego, California

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF

CERTIFICATE OF DEATH

Registered No. 181

No. MISSION VALLEY INN, Room 323

XX (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME ERNEST CLARENCE DAVIS, JR.
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR.)(a) Residence. No. 92 Upland Road
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH June 10 1961 (Month) (Day) (Year)	8 SEX Male	9 COLOR White	10 SINGLE (write the word) MARRIED WIDOWED Married or DIVORCED
4 I HEREBY CERTIFY, That I attended deceased from			

STATE
COUNTY

61-068041

CERTIFICATE OF DEATH

STATE OF CALIFORNIA - DEPARTMENT OF PUBLIC HEALTH

LOCAL REGISTRATION

DISTRICT AND 8009

CERTIFICATE NUMBER

1a NAME OF DECEASED - FIRST NAME Ernest	1b MIDDLE NAME Clarence	1c LAST NAME DAVIS Jr.	2a DATE OF DEATH - MONTH DAY YEAR June 10, 1961	2b HOUR 11:20 A.M.
3 SEX Male	4 COLOR OR RACE Cauc.	5 BIRTHPLACE New York	6 DATE OF BIRTH May 31, 1917	7 AGE LAST BIRTHDAY 44 YEARS
8 NAME AND BIRTHPLACE OF FATHER Ernest C. Davis Sr. N. Y.	9 MAIDEN NAME AND BIRTHPLACE OF MOTHER Unknown Unknown, New York	10 CITIZEN OF WHAT COUNTRY U.S.A.	11 SOCIAL SECURITY NUMBER 009-03-7128	
12 LAST OCCUPATION Turbine Planning	13 NUMBER OF YEARS IN THIS OCCUPATION 10	14 NAME OF LAST EMPLOYING COMPANY OR FIRM Northeast Airlines	15 KIND OF INDUSTRY OR BUSINESS Airlines	
16 PRESENT OR LAST PLACE OF RESIDENCE Unknown	17 NAME OF MARRIED SPOUSE Married	18a NAME OF PRESENT SPOUSE Dorothy Davis	18b PRESENT OR LAST OCCUPATION OF SPOUSE Homemaker	
19a PLACE OF DEATH - PART OF HOSPITAL Mission Valley Inn, Room 323	19b STREET ADDRESS - GIVE STREET OR RURAL ADDRESS OR LOCATION 875 W. Camino Del Rio	19c COUNTY San Diego	19d LENGTH OF STAY IN COUNTY OF DEATH 1 Day	19e LENGTH OF STAY IN CALIFORNIA 1 Day
20a LAST USUAL RESIDENCE 92 Upland Road	20b CITY OR TOWN Winthrop	20c COUNTY Suffolk	20d STATE Mass.	20e ADDRESS OF INFORMANT Kirby Funeral Home
21a PHYSICIAN (If death occurred at home, give name of physician who attended the deceased) A. J. GALLAGHER, M.D.	21b CORONER (If death occurred at home, give name of coroner who attended the deceased) Benjamin J. Williams, M.D.	21c ADDRESS 3322 Congress Street	21d DATE SIGNED 6/10/61	
22a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	22b NAME OF CEMETERY OR CREMATORY Local Cemetery	22c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	22d DATE OF DEATH	
23a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	23b NAME OF CEMETERY OR CREMATORY Local Cemetery	23c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	23d DATE OF DEATH	
24a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	24b NAME OF CEMETERY OR CREMATORY Local Cemetery	24c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	24d DATE OF DEATH	
25a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	25b NAME OF CEMETERY OR CREMATORY Local Cemetery	25c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	25d DATE OF DEATH	
26a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	26b NAME OF CEMETERY OR CREMATORY Local Cemetery	26c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	26d DATE OF DEATH	
27a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	27b NAME OF CEMETERY OR CREMATORY Local Cemetery	27c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	27d DATE OF DEATH	
28a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	28b NAME OF CEMETERY OR CREMATORY Local Cemetery	28c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	28d DATE OF DEATH	
29a NAME OF FUNERAL DIRECTOR Johnson-Saum & Knobel Mort.	29b NAME OF CEMETERY OR CREMATORY Local Cemetery	29c EMPLOYER'S SIGNATURE (If not employed, LICENSE NUMBER)	29d DATE OF DEATH	
30 CAUSE OF DEATH	PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a Occlusion of left anterior descending coronary artery			
31 CAUSE OF DEATH	PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Thrombosis, Atherosclerosis.			

NON RESIDENT ALLOCATIONS FOR PUBLIC HEALTH PROGRAM & STATISTICAL PURPOSES ONLY

HEALTH DATA

Received and filed 10-13-61

(Registrar of City or Town where deceased resided)

DATE FILED (Registrar of City or Town where death occurred)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

To be filed for burial permit
with Board of Health
or its Agent.

182

Registered No. 06021

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Jennie C. Bowers (Butler)

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, no
if so specify WAR)(a) Residence No. 779 Shirley
(Usual place of abode)

St. Winthrop, Massachusetts

(If nonresident, give city or town and State)

Length of stay: In place of death years months 3 days In place of residence years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 23, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That we attended deceased from
June 20, 61, to June 23, 61
We last saw her alive on June 23, 1961, death is said to
have occurred on the date stated above, at 1:05 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

INTERVAL
BETWEEN
ONSET AND
DEATH(b) Intertrochanteric fracture
3 days(c) Due To of right hip
3 daysOTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed)

Charles L. Clay, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 6-23-61

South Thomaston Cem., S. Thomaston
Place of Burial or Cremation (Maine town)

DATE OF BURIAL June 26, 1961

NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop

Received and filed JUN 26 1961

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED widowed10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of George Fred Bowers
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 39 Years 10 Months 5 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) South Thomaston
(State or country) Maine

17 NAME OF FATHER William R. Butler

18 BIRTHPLACE OF FATHER (City) South Thomaston
(State or country) Maine

19 MAIDEN NAME OF MOTHER Julia A. Sartelle

20 BIRTHPLACE OF MOTHER (City) Camden
(State or country) Maine21 Informant Mrs. Ava MacDonald
(Address) 779 Shirley St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST

Charles A. Macrie

City Registrar

RECEIVED



OCT 25 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT OF TOWN
To be filed for burial permit
with Board of Health
or its Agent
183-
06298

Suffolk

(County)

Boston

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Children's Hospital Medical Center

Registered No.

No. St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{ (Was deceased a
U. S. War Veteran,
if so specify WAR) NO

2 FULL NAME Pivnick Gerald
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

38 Forrest

Winthrop

(a) Residence, No.
(Usual place of abode)

St.

Length of stay: In place of death years months days. In place of residence years months days. (If nonresident, give city or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 3, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY that I attended deceased from 7-1 1961 7-3 1961

I last saw him alive on 7-3 1961, death is said to have occurred on the date stated above, at 1:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Sepsis

Due To (b) Pyramoglobulinemia

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes (Searched)

What test confirmed diagnosis? Gamma Globulin Level

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Beale H. Ong, M. D.

(Address) 300 Longwood Ave. Date 7-3-61

6 LINAS HATZEDER EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 4 1961

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SV.

ADDRESS Chelsea

Received and filed JUL 6 1961

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

MALE WHITE MARRIED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 14 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: S.T. DENT (Kind of work done during most of working life)

14 Industry or Business: PUBLIC SCHOOLS WINTROP

15 Social Security No. NONE

16 BIRTHPLACE (City) WALTHAM MASS (State or country)

17 NAME OF FATHER DAVID PIVNICK

18 BIRTHPLACE OF FATHER (City) CHELSEA (State or country) MASS.

19 MAIDEN NAME OF MOTHER SYLVIA WOLKON

20 BIRTHPLACE OF MOTHER (City) CHELSEA (State or country) MASS.

21 Informant (Address) DAVID PIVNICK 38 FORREST ST. WINTROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

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Chapter 137,
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25 1961

028145

Note: Classified to Anemia-Hemoglobin deficiency.

EX 21

11700-1001

Charles A. Mackie

City Registrar

Grand Juror

RECEIVED



OCT 25 1961 AM

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25 1961

To be filed for burial permit
with Board of Health
or its Agent. 184

16325

Registered No.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No.

MASS. MEMORIAL HOSP.

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

RICHARD

TRODERMAN

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name)

{(Was deceased a

{U. S. War Veteran,

{if so specify WAR) W.W.I.

(a) Residence, No.

(Usual place of abode)

85 BEACH ROAD

WINTHROP, MASS.

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months 29 hrs. days. In place of residence 25 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

JULY

5

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
JULY 4, 1961, to JULY 5, 1961I last saw him alive on JULY 5, 1961, death is said to
have occurred on the date stated above, at 6 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

CORONARY HEART DISEASE

(a)

INTERVAL
BETWEEN
ONSET AND
DEATHDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

PEPTIC ULCER

Was autopsy performed?

No

What test confirmed diagnosis?

NONE

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

Paul C. Barsam

M. D.

PAUL C. BARSAM

(PRINT OR TYPE SIGNATURE)

(Address)

MASS. MEM. HOSP.

Date JULY 5, 1961

6 Vilkomer Cemetery Melrose

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

July 6, 1961

7 NAME OF
FUNERAL DIRECTOR

Benjamin F. Solomon

ADDRESS

420 Harvard St Brookline

Received and filed

JUL 12 1961

Charles H. Mackie

(REGISTERAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

W

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

MARRIED

10a If married, widowed, or divorced
HUSBAND of

Bertrude (Speck)

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

63

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

Millinery

(Kind of work done during most of working life)

14 Industry

or Business:

OWNER

15 Social Security No.

CNB1

16 BIRTHPLACE (City)

(State or country)

Russia

17 NAME OF

FATHER

Samuel Troderman

18 BIRTHPLACE OF

FATHER (City)

Russia

(State or country)

19 MAIDEN NAME

OF MOTHER

Rose Michaels

20 BIRTHPLACE OF

MOTHER (City)

Russia

(State or country)

21

Informant

(Address)

Seymour Solett son-in-law

31 West Boulevard Pelham N.Y.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

11.10.

A TRUE COPY ATTEST.

Charles H. Mackie

City Registrar

RECEIVED



OCT 25 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent.

185

106151

Registered No.

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NOPLACE OF DEATH
1 SUFFOLK
(County)
BOSTON
(City or Town)

No. FAULKNER HOSPITAL

2 FULL NAME WILLIAM HENRY WALPOLE

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 119 RIVER STREET RD
(Usual place of abode)

WINTHROP, MASS

(If nonresident, give city or town and State)

Length of stay: In place of death, ... years, ... months, 9 days. In place of residence 30 years, ... months, ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 7 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JUNE 26, 1961, to JULY 7, 1961I last saw him alive on JULY 7, 1961, death is said to
have occurred on the date stated above, at 2:37A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE RENAL FAILURE

INTERVAL
BETWEEN
ONSET AND
DEATH
60 days

Due To

(b) LOWER NEPHRON NEPHROSIS

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS ACUTE MECKLES
DIVERTICULOSIS

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) FRANKLIN C. BALCH JR. M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 1180 BEDFORD ST Date 7/7/61 19

BOSTON, MASS

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 10 1961

7 NAME OF FUNERAL DIRECTOR Maurice W. Ruby

ADDRESS WINTHROP

Received and filed JUL 11 1961

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)
MALE WHITE MARRIED
or WIDOWED or DIVORCED10a If married, widowed, divorced
HUSBAND of BERTHA L O'HARA
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: WHOLESALE PAPER MGR.
(Kind of work done during most of working life)

14 Industry or Business: PRINTING PAPER

15 Social Security No.

16 BIRTHPLACE (City) MILFORD
(State or country) MASS

17 NAME OF FATHER JOHN F WALPOLE

18 BIRTHPLACE OF FATHER (City) MILFORD
(State or country) MASS

19 MAIDEN NAME OF MOTHER MARY A GERMANI

20 BIRTHPLACE OF MOTHER (City) MILFORD
(State or country) MASS21 Informant MR. BERTHA L WALPOLE
(Address) 119 RIVER RD WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:No in Damam
(Signature of Agent of Board of Health or other)2803
(Official Designation)7-7-61
(Date of Issue of Permit)

R-301A

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25 1961

8145

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



OCT 25 1961 AM

-THIS IS A
NMENT RECORD.
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APPROVED
ink or black
riter ribbon.

INSTRUCTIONS
FOR
CERTIFICATE

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OF DEATH

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(b) and (c)

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AP. 46:§ 9 &
P. 114:§ 45,
AP. 38:6.)

25 1961

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 165,023

1 PLACE OF DEATH
Suffolk
(County)
Boston
(City or Town)



2 FULL NAME Boston-lying-In-Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)
Baby, FRANKIS Duggan (If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Residence. No. 286 Perere St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death _____ years _____ months _____ days. In place of residence _____ years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH <u>July 8, 1961</u> (Month) (Day) (Year)		8 SEX <u>Male</u>	9 COLOR <u>White</u>
4 I HEREBY CERTIFY That I attended deceased from <u>July 6, 1961</u> to <u>July 8, 1961</u> I last saw him alive on <u>July 8, 1961</u> , death is said to have occurred on the date stated above, at <u>3:15 A.m.</u>		10 SINGLE (write the word) <u>MARRIED</u> <u>WIDOWED</u> <u>or DIVORCED</u> <u>Single</u>	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>Subarachnoid hemorrhage</u> Due To (b) <u>UNKNOWN</u>		10a If married, widowed, or divorced HUSBAND of _____ (Give maiden name of wife in full) (or) WIFE of _____ (Husband's name in full)	
OTHER SIGNIFICANT CONDITIONS _____		11 IF STILLBORN, enter that fact here.	
Was autopsy performed? <u>YES</u> What test confirmed diagnosis? <u>Autopsy</u>		12 AGE _____ Years _____ Months <u>1</u> Days If under 24 hours _____ Hours _____ Minutes	
5 Was disease or injury in any way related to occupation of deceased? If so, specify _____		13 Usual Occupation: _____ (Kind of work done during most of working life)	
(Signed) <u>John J. Dussell</u> , M. D. (Address) <u>39 Longwood Ave.</u> Date <u>7/8/1961</u>		14 Industry or Business: _____	
6 <u>Winthrop Cemetery</u> <u>Winthrop</u> Place of Burial or Cremation (City or Town)		15 Social Security No. _____	
DATE OF BURIAL <u>July 10, 1961</u>		16 BIRTHPLACE (City) <u>Boston</u> (State or country) <u>Massachusetts</u>	
7 NAME OF FUNERAL DIRECTOR <u>Arthur J. O'Maley</u> ADDRESS <u>Winthrop, Mass</u>		17 NAME OF FATHER <u>Daniel Joseph Duggan</u>	
Received and filed <u>JUL 12 1961</u>		18 BIRTHPLACE OF FATHER (City) <u>Chelsea</u> (State or country) <u>Massachusetts</u>	
<u>Charles H. Ina</u>		19 MAIDEN NAME OF MOTHER <u>Margaret Flannery</u>	
		20 BIRTHPLACE OF MOTHER (City) <u>Winthrop, Mass.</u> (State or country)	
		21 Informant <u>Boston-lying-In-Hospital</u> (Address) <u>221 Longwood Ave.</u>	
		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: <u>Jacqueline Dorato</u> (Signature of Agent of Board of Health or other)	
		2815 7 10 61 (Official Designation) (Date of Issue of Permit)	

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



OCT 25 1961 AM

CERTIFICATE

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Chapter 137,
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25 1961

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. CHILDREN'S HOSPITAL MEDICAL CENTER, {If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

MICHELLE

WOOD

2 FULL NAME

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No.

30 PLUMMER AVE.

St. WINTHROP, MASSACHUSETTS

HOSPITAL (Place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years 1 months 1 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 12 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That attended deceased from
JUNE 11 1961 to JULY 12 1961I last saw h..... alive on JULY 12 1961, death is said to
have occurred on the date stated above, at 4:40 A.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MULTIPLE CONGENITAL ANOMALIES

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

P. B. ROSENBERGER, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 300 LONGWOOD AVE Date JULY 12 1961

6 Wintthrop Cemetery Wintthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL

July 13

1961

7 NAME OF
FUNERAL DIRECTOR

Ernest P. Berglund

ADDRESS

147 Wintthrop St. Wintthrop

Received and filed JUL 14 1961

Charles H. Mackie (Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent. 187

Registered No. 06590

PHYSICIAN — IMPORTANT

{(Was deceased a
{ U. S. War Veteran.
{ if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED

Single

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 1 month 3 days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

(Kind of work done during most of working life)

14 Industry

or Business:

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Wintthrop
Mass.17 NAME OF
FATHER

Frederick Wood

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Middlebury
Vermont

19 MAIDEN NAME

OF MOTHER

Mary O'Byrn

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Brandon
Vermont

21

Informant

(Address)

Frederick Wood
30 Plummer Ave WintthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

2802

(Official Designation)

7-12-61

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

Clerk Registrar

RECEIVED



OCT 25 1961 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-326111

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 344

No. Soldiers' Home Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Albert Wright (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, WWI)

(a) Residence. No. 100a Summit Ave. / Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 0 years 0 months 10 days. In place of residence 35 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 15, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 6, 1961 to July 15, 1961 I last saw him live on July 15, 1961, death is said to

have occurred on the date stated above, at 12:30 A.M. INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Perforated duodenal ulcer

Due To with peritonitis (b)

Due To Arteriosclerotic heart disease-congestive heart failure (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Klaus G.M.Reverdy M. D. (Address) Soldiers' Home Hosp. 7/15/61

6 Milton Cem., Milton, Mass. (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL July 18, 1961 19

7 NAME OF FUNERAL DIRECTOR Arthur J.O'Maley Winthrop, Mass. ADDRESS

Received and filed OCT 10 1961 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Married

10a If married, widowed, or divorced HUSBAND of Irene Doherty (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 11 23 (If under 24 hours) Hours Minutes

13 Usual Occupation: Investigator (Kind of work done during most of working life)

14 Industry or Business: not known

15 Social Security No. 010-03-7529

16 BIRTHPLACE (City) (State or country) Boston, Mass.

17 NAME OF FATHER James F.Wright

18 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass.

19 MAIDEN NAME OF MOTHER Elizabeth Magee

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Office, Chelsea, Mass. (Address)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED July 15, 1961 19

✓



SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE Aug. 7, 1918 OCT - 9 1961 AM
DATE OF DISCHARGE Apr. 30, 1919
RANK, RATING Private
ORGANIZATION AND OUTFIT U.S. Marine Corp.
SERVICE NUMBER 136803
.....

PLACE OF DEATH

Suffolk

(County)

East Boston

(City or Town)

No. Princeton-Shelby Nursing Home

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.189
07062

Registered No.

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frances Yvonne Lanou Dasch

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 44 Cottage Park Road

St Winthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years..... 5 months..... days. In place of residence 31 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 24 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Nov. 4, 1949, to July 24, 1961.
I last saw her live on JULY 24, 1961, death is said to
have occurred on the date stated above, at 2:40 P. m.INTERVAL
BETWEEN
ONSET AND
DEATH
8 MO.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS
WITH PARAPLEGIA

(b) DUE TO METASTASIS TO SPINE

(c) DUE TO ADEQUATE CARCINOMA RT. BREAST 4 1/4 YRS

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? OPERATION + CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King M. D.

(Address) 222 PLEASANT ST WINTHROP Date JULY 26 1961

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 27, 1961

7 NAME OF FUNERAL DIRECTOR

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUL 27 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Eugene Carl Dasch
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years 6 Months 20 Days If under 24 hours
Hours..... Minutes13 Usual Occupation: admitting clerk
(Kind of work done during most of working life)

14 Industry or Business: Winthrop Community Hospital

15 Social Security No. 023-18-3889

16 BIRTHPLACE (City) Burlington
(State or country) Vermont

17 NAME OF FATHER Frank S. Lanou

18 BIRTHPLACE OF FATHER (City) St. Jacques
(State or country) Quebec

19 MAIDEN NAME OF MOTHER Emilie Rousseau

20 BIRTHPLACE OF MOTHER (City) Burlington
(State or country) VermontInformant Eugene Carl Dasch, Jr.
(Address) 44 Cottage Park Road, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

3049 7/26/61
(Official Designation) (Date of Issue of Permit)CTIONS
OR
CERTIFICATEiving
OF DEATHt enter
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76

Chapter 137,
95A, requires
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48, Acts of
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print or type
er signature.

25 1961

A TRUE COPY ATTACHED

W. B. Mackie

LINE REGISTRAR

RECEIVED



OCT 25 1961 AM

Information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 35, § 6, 20; Chap. 46, § 9, 10; Chap. 114, § 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-6-60-9281/5

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent

Registered No.

MASSACHUSETTS GENERAL HOSPITAL

No. St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME **FREDERICK B. HARTY**
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{ (Was deceased a
{ U. S. War Veteran,
{ if so, specify WAR) **W.W.#1**

(a) Residence, No. St. **Winthrop, Mass.**
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence **25** years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **August 2, 1961**
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Pulmonary embolus following fracture of femur; Parkinsonism.

5 Accident, suicide, or homicide (specify) **Accident.**
Date and hour of injury **July 3, 1961**

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur? **Plymouth, Mass.**
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? **Hospital.**

Manner of injury **Fall from chair.**
(Specify type of place)

Nature of injury **(How did injury occur?)**

While at work? Was autopsy performed? **Yes.**

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) **Michael A. Luongo, M.D.**

(Address) **Boston** Date **8/3 1961**
(Print or Type Signature)

7 **Cedar Grove Cem** **Boston Mass**
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL **August 7, 1961**

8 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**

ADDRESS **Winthrop, Mass**

Received and filed **AUG 8 1961**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Male** 10 COLOR **White** 11 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED

11a If married, widowed or divorced,
HUSBAND of **Margaret M. Caffrey**
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE **70** Years, Months, Days If under 24 hours
..... Hours, Minutes

14 Usual Occupation: **Retired Investment Broker**
(Kind of work done during most of working life)

15 Industry or Business: **Stocks & Bonds**

16 Social Security No. **033-26-0792**

17 BIRTHPLACE (City) **Boston**
(State or country) **Mass**

18 NAME OF FATHER **James Harty**

19 BIRTHPLACE OF FATHER (City) **Petersham**
(State or country) **Mass**

20 MAIDEN NAME OF MOTHER **Rose Fitzgerald**

21 BIRTHPLACE OF MOTHER (City) **Easthampton**
(State or country) **Mass**

22 Informant **Margaret M. Harty**
(Address) **158 Highland Ave., Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) **918877** (Date of Issue of Permit) **8/4/61**

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



OCT 25 1961 AM

R-301A

CTIONS
OR
CERTIFICATEiving
F DEATHt enter
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25 1961

X 28145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

OUT OF TOWN

To be filed for burial permit
with Board of Health
or its Agent. 191

197182

Registered No.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie Grinnell

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a

{ U. S. War Veteran,

{ if so specify WAR)

no

(a) Residence No. 26 Emerson Road
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death years months 1 days. In place of residence 60 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 7 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
August 7 1961 to August 7 1961
I last saw him alive on August 7 1961 death is said to
have occurred on the date stated above, at 9:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Edema

Due To

(b) Myocardial Infarction

Due To Old with recent extension

(c) Coronary Heart Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Charles L. Clay, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l Hosp. Date August 7 1961

6 Fairview Cemetery Jefferson, Me.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 10 1961

7 NAME OF FUNERAL DIRECTOR Richard Hall, F.D.A.

ADDRESS Waldoboro, Maine

Received and filed August 8 1961

Charles H. Thacker (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED

WIDOWED

or, DIVORCED

F

W

Single

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 68 Years 0 Months 6 Days

If under 24 hours

Hours Minutes

13 Usual Occupation: Stenographer

(Kind of work done during most of working life)

14 Industry or Business: Various Industries

15 Social Security No. no

16 BIRTHPLACE (City) Appleton, Maine
(State or country)

17 NAME OF FATHER George Grinnell

18 BIRTHPLACE OF FATHER (City) Appleton, Maine
(State or country)

19 MAIDEN NAME OF MOTHER Lucinda Grinnell

20 BIRTHPLACE OF MOTHER (City) Appleton, Maine
(State or country)

21 Edward Grinnell

Informant (Address) R.F.D. Appleton, Maine

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

A18908 (Official Designation)

Aug 8 1961 (Date of Issue of Permit)

Charles H. Mackie
City, Massachusetts

RECEIVED



OCT 25 1961 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-426111

1

PLACE OF DEATH

Middlesex

(County)

Melrose

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Melrose

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 192

No. Melrose-Wakefield Hospital

{ (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Aloysius Flannery

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a U. S. War Veteran, if so specify WAR, W W I

(a) Residence, No. 73 Orchard Lane

(Usual place of abode)

St. Melrose, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....7.....days. In place of residence.....8.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 21, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1961 to September 21, 1961

I last saw him alive on September 21, 1961, death is said to

have occurred on the date stated above, at 9:05 A. m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive Heart Failure

weeks

Due To Hypertensive Cardiovascular

(b) Heart Disease

years

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

No

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John S. Graf

M. D.

(Address) Melrose, Mass.

Date Sept. 22, 1961

6 Winthrop

Winthrop, Mass.

Place of Burial or Cremation

DATE OF BURIAL September 23, 1961

7 NAME OF FUNERAL DIRECTOR John H. Cately

ADDRESS Melrose, Mass.

Received and filed OCT 10 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED Married
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of Father G. O'Neil

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 68 Years 8 Months 28 Days

If under 24 hours

.....Hours.....Minutes

13 Usual

Occupation:

President

(Kind of work done during most of working life)

14 Industry

or Business:

National Lobster Co.

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

East Boston
Mass.

17 NAME OF FATHER

Peter Flannery

18 BIRTHPLACE OF FATHER (City)

(State or country)

Unable to obtain
Ireland

19 MAIDEN NAME

OF MOTHER

Bridget Kennedy

20 BIRTHPLACE OF MOTHER (City)

(State or country)

Unable to obtain
Ireland

21

Informant

(Address)

Mrs. Peter A. Flannery

73 Orchard Lane, Melrose, Mass.

A TRUE COPY

Raymond H. Greenlaw.

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

September 25, 1961

19

X



OCT 10 9 1961 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE Oct. 5 - 1917

DATE OF DISCHARGE Nov. 8 - 1917

RANK, RATING Private

ORGANIZATION AND OUTFIT U. S. Army Machine Gun Co. 301st Inf.

SERVICE NUMBER

.....

PLACE OF DELIVERY

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

2 NAME OF FETUS
(if given)

Baby Boy Cutler

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF FETAL DEATH
(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 193

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)3 DATE OF DELIVERY Oct 4, 1961
(Month) (Day) (Year)4 SEX
Male ☒ Female ☐ Undetermined ☐5 COLOR (if
determined) W6 THIS BIRTH (Check one)
Single ☒ Twin ☐ Triplet ☐7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd8
FULL
NAMEFATHER
Robert Cutler9 RESIDENCE, NO. 25 Alden Ave
CITY OR TOWN Revere STATE Mass10 COLOR OR RACE White 11 AGE AT TIME OF
THIS DELIVERY 35 (Years)12 PLACE OF BIRTH Chelsea Mass
(City or Town) (State or country)

13 OCCUPATION Self Employed

14 MAIDEN NAME Esther Jaffe
PRESENT NAME Esther Cutler15 RESIDENCE, NO. 25 Alden Ave
CITY OR TOWN Revere Mass STATE16 COLOR OR RACE White 17 AGE AT TIME OF
THIS DELIVERY 32 (Years)18 PLACE OF BIRTH Chelsea Mass
(City or Town) (State or country)

19 INFORMANT Robert Cutler

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

4

(a) How many children are
now living? 4(b) How many children were
born alive but are now
dead? 0(c) How many previous fetal
deaths of ANY gestation
age? 021 LENGTH OF
PREGNANCY 37 completed weeks22 WEIGHT OF FETUS
6 Lb. 8 Oz.
(or Grams)23 WHEN DID FETUS DIE?
Before Labor ☒ During Labor ☐ or Delivery ☐ Unknown ☐24 AUTOPSY
Yes ☒ No ☐

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Asphyxia In utero

Due To (b)

Due To (c)

OTHER SIGNIFICANT
CONDITIONS26 Workmans Circle MELROSE
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct 6 196127 NAME OF FUNERAL DIRECTOR TORF Funeral Service Inc
ADDRESS 151 Washington Ave Chelsea

Received and filed

OCT 6 1961

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 4:59 P.M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Morris I. Sacks M.D.

MORRIS I. SACKS M.D.
(PRINT OR TYPE SIGNATURE)

Address 45 Shirley Ave. Revere Date Oct 6 1961

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sieranin
(Signature of Agent of Board of Health or other)H.O.
(Official Designation)Oct. 6-1961
(Date of Issue of Permit)



EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE

 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS
 MEDICAL EXAMINER'S
 CERTIFICATE OF DEATH

 To be filed for burial permit
 with Board of Health
 or its Agent.

Registered No. 194

90 Highland Avenue, Winthrop

No. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME THOMAS A. Mac CRINDLE, SR. (First Name) (Middle Name) (Last Name)

 PHYSICIAN - IMPORTANT
 (Was deceased a U. S. War Veteran, if so specify WAR)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No. 228 Bowdoin Street, Winthrop (Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months days In place of residence 25 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 9, 1961 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

CORONARY OCCLUSION

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

(Print or Type Name)

(Address) Boston Date 10/9/61

7 Winthrop Winthrop

Place of Burial, or Cremation (City or Town)

DATE OF BURIAL Oct 13 1961

8 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St, Winthrop

Received and filed OCT 11 1961 19

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

 9 SEX Male 10 COLOR White 11 CITIZEN OF U.S. YES ☒ NO ☐ 12 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

12a If married, widowed or divorced, HUSBAND of Ruth E Phillips (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH Dec 28 1892

14 AGE 69 Years 6 Months 9 Days If under 24 hours Hours Minutes

15 Usual Occupation: Painter (Kind of work done during most of working life)

16 Industry or Business: Painting Business

17 Social Security No. 014-18-2940

18 BIRTHPLACE (City) East Boston (State or country) Mass

19 NAME OF FATHER Thomas Mac Crindle

20 BIRTHPLACE OF FATHER (City) Scotland (State or country)

21 MAIDEN NAME OF MOTHER Mary White

22 BIRTHPLACE OF MOTHER (City) Scotland (State or country)

23 Informant Thomas Mac Crindle (Address) 228 Bowdoin St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) Health Officer (Date of Issue of Permit) 10/11/61

V.O.

information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **195**

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME James William Bolger

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, NO.
if so specify WAR)}

(a) Residence. No. 434 Revere Street
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....3 days. In place of residence.....30 years.....months.....days.

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
condition given

Chapter 137,
954, requires
is to print or
cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 10, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
October 5, 1961, to Oct. 10, 1961

I last saw him alive on Oct. 10, 1961, death is said to
have occurred on the date stated above, at 11:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Embolus

INTERVAL
BETWEEN
ONSET AND
DEATH

3 days

Due To (b) Rheumatic Heart Disease 10 yrs

Due To (c) Mitral Stenosis 10 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis Clinical and Post Mortem

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M.D.
Charles Liberman, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 10/11/1961

6 Woodlawn Cemetery Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 16, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed OCT 11 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED married
WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Bertha Waldenhauer
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years 0 Months 11 Days If under 24 hours Hours Minutes

13 Usual Occupation: power plant engineer
(Kind of work done during most of working life)

14 Industry or Business: Metropolitan District Com.

15 Social Security No. none

16 BIRTHPLACE (City) St. John's
(State or country) New Foundland

17 NAME OF FATHER Edward Bolger

18 BIRTHPLACE OF FATHER (City) St. John's
(State or country) New Foundland

19 MAIDEN NAME OF MOTHER Ellen Rutledge

20 BIRTHPLACE OF MOTHER (City) St. John's
(State or country) New Foundland

21 Informant Mrs. James W. Bolger
(Address) 434 Revere St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Seranous
(Signature of Agent of Board of Health or other)

Health Officer 10/11/61
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

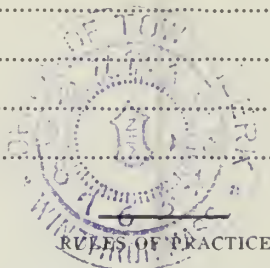
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

t enter
than one
for each
b) and (c)

s not mean
of dying,
heart failure,
etc. It means
or compli-
which caused

s, if any,
ve rise to
ause (a),
he under-
use last.

ons contrib-
ath but not
he terminal
dition given

Chapter 137,
954, requires
is to print or
cause or
f death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Convalescent Home
142 Pleasant St.

2 FULL NAME Bertha M. Dennison (Kempton)

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 164 Vane Street

(Usual place of abode)

St. Revere

(If nonresident, give city or town and State)

Length of stay: In place of death years months 1 days. In place of residence 65 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 10, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Aug 30, 1961, to Oct 10, 1961I last saw him alive on Oct 10, 1961, death is said to
have occurred on the date stated above, at 1130 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY Thrombosis

Due To (b) Rheumatic Heart Dz 20 yrs.

Due To (c) Generalized Arteriosclerosis 30 yrs.

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Morris I. Sacks, M.D.

MORRIS I. SACKS, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 45 Shirley Ave Revere Oct 10, 1961

6 Locust Grove Rockport
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 13, 1961

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike

ADDRESS 305 Beach St. Revere

Received and filed OCT 13 1961

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 196

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of(Give maiden name of wife in full)
(or) WIFE of Frank E. Dennison
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 11 Months 2 Days If under 24 hours
Hours Minutes13 Usual Occupation: At home
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City or State or country) Nova Scotia

17 NAME OF FATHER Isaac Kempton

18 BIRTHPLACE OF FATHER (City or State or country) Unable to learn
Nova Scotia

19 MAIDEN NAME OF MOTHER Mary Parker

20 BIRTHPLACE OF MOTHER (City or State or country) Nova Scotia

21 Informant Herbert Dennison
(Address) 164 Vane St. RevereI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) Health Officer 10/13/61
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



OCT 13 1961 AM

RECEIVED

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No.

197

No. Winthrop Convalescent Home St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME Ada Grisdale (Pow)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)(a) Residence, No. Winthrop Convalescent Home St. (If nonresident, give city or town and State)
(Usual place of abode)Length of stay: In place of death 1 years 3 months 12 days, In place of residence _____ years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCT 10 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
_____, 1950, to OCT 10, 1961
I last saw her alive on OCT 7, 1961, death is said to
have occurred on the date stated above, at 5:30 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH10 yrs

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) General arteriosclerosisDue To
(b) _____Due To
(c) _____OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____(Signed) Charles Meloni, M. D.(Address) 305 Haver & E. B. St. Date OCT 10 19616 Wyoming Cem. Melrose
Place of Burial or Cremation (City or Town)DATE OF BURIAL Fri. October 13 19617 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.
ADDRESS 917 Bennington St E.B.Received and filed OCT 11 1961 19____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed10a If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)(or) WIFE of Thomas Grisdale
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 93 years 10 months 10 days If under 24 hours
— Hours — Minutes13 Usual Occupation: House Wife
(Kind of work done during most of working life)14 Industry or Business: At Home15 Social Security No. none16 BIRTHPLACE (City) Liverpool England
(State or country)17 NAME OF FATHER Frederick Pow18 BIRTHPLACE OF FATHER (City) Liverpool, England
(State or country)19 MAIDEN NAME OF MOTHER CBL20 BIRTHPLACE OF MOTHER (City) Liverpool England
(State or country)21 Informant Mrs. Frederick Neilsen
(Address) 18 Crestway Rd. E.B.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Lemanne
(Signature of Agent of Board of Health or other)Health Officer 10/11/61
(Official Designation) (Date of Issue of Permit)

X

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the cause of death, the date of his death, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. . . for the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border treaty of nineteen hundred and sixteen and nineteen hundred and seventeen. . . L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and move it from a town, from one cemetery to another, or from one grave or tomb to another than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

PLACE OF DEATH

Worcester

(County)

Westborough

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Westborough

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 198

Westborough State Hospital

{(If death occurred in a hospital or institution, give its NAME instead of street and number)}

2 FULL NAME Charles H. Ide

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR.)}

(a) Residence. No. 163 Pleasant

(Usual place of abode)

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death. 45 years.....months.....days. In place of residence. 36 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 10, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 10 1961 to Oct. 10 1961
1 last saw him alive on Oct. 10, 1961 death is said to have occurred on the date stated above, at 5:15p.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease

Due To Arteriosclerosis, Generalized

Due To

OTHER SIGNIFICANT CONDITIONS Senility

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Arthur H. Mayboy M. D.
(Address) Westboro, Mass. Date 10/10/61

6 Winthrop Cem. Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 13, 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS Winthrop, Mass.

Received and filed OCT 26 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Single

11a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 3 Years.....Months.....Days If under 24 hoursHours.....Minutes

13 Usual Occupation: Salesman (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Brooklyn, (State or country) N.Y.

17 NAME OF FATHER Edwin Ide

18 BIRTHPLACE OF FATHER (City) Wrentham, (State or country) Mass.

19 MAIDEN NAME OF MOTHER Alice Cummings

20 BIRTHPLACE OF MOTHER (City) Brebble, (State or country) N.Y.

21 Informant Westborough State Hospital (Address) Records

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED October 19, 1961

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 199

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 480 Winthrop Street

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

2 FULL NAME Joseph Sasso
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) no

(a) Residence, No. 480 Winthrop Street St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 5 years 5 months 5 days. In place of residence 5 years 5 months 5 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 11 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19 to 19

I last saw him alive on 19 , death is said to
have occurred on the date stated above, at 9:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To (b) Presumably Coronary
Due To (c) Occlusion

INTERVAL
BETWEEN
ONSET AND
DEATH

Sudden

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease

Was autopsy performed? no
What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray M. D.
Arthur C. Murray
(PRINT OR TYPE SIGNATURE)
Winthrop Board of Health 12 Oct 61
(Address)

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 14, 1961

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed OCT 13 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
or DIVORCED

10a If married, widowed, or divorced Marion DeBueris
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 72 AGE Years Months Days If under 24 hours
 Hours Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: Shoe Cutler

15 Social Security No. 022-05-5511

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

17 NAME OF FATHER Joseph Sasso

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Maria Ann (unknown)

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Marion Sasso (wife)
(Address) 480 Winthrop St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lincum
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 10/13/61 (Date of Issue of Permit)

R-301A

CERTIFICATE

DEATH

enter
an one
or each
) and (c)

not mean
of dying,
art failure,
It means
or compli-
ch caused

if only,
e rise to
use (o),
e under-
se lost.

ns contrib-
th but not
e terminal
ition given

Chapter 137,
54, requires
to print or
cause or
death on
ificates, and
8, Acts of
ires Physi-
int or type
r signature.

8145

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



OCT 13 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 200

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary G. Fitzpatrick

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 63 Summit Ave.

St. Winthrop

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 1 years 28 months 50 days. In place of residence 50 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 12, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1955, to Oct. 12, 1961.
I last saw her alive on Oct. 11, 1961, death is said to have occurred on the date stated above, at 7:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

Due To (b) Hypertension

Due To (c) Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS None

INTERVAL BETWEEN ONSET AND DEATH

2 months

8 yrs.

15 yrs

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED
WIDOWED Single or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 0 Months 0 Days If under 24 hours 0 Hours 0 Minutes

13 Usual Occupation: Hostess (Retired)
(Kind of work done during most of working life)

14 Industry or Business: Restaurant

15 Social Security No. 000-00-0000

16 BIRTHPLACE (City) South Boston
(State or country) Mass

17 NAME OF FATHER William Fitzpatrick

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Ann Dunn

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant (Address) Eleanor Corcoran
63 Summit Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial, or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

DATE OF BURIAL October 14, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed Oct 13 1961 19

(Registrar)

R-301A

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SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



OCT 13 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 201

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)}

2 FULL NAME Annette (DeLuca)

(First Name)

(Middle Name)

Stasio

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)}

PHYSICIAN — IMPORTANT

(a) Residence, No. 149 Somerset Ave.

(Usual place of abode)

St. Winthrop Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death years months 1 days. In place of residence 12 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCT 13 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
APRIL 10, 1956, to OCT 13, 1961I last saw her alive on OCT 13, 1961, death is said to
have occurred on the date stated above, at 8:25 P. M.DEATH WAS CAUSED BY: IMMEDIATE CAUSE
ANTERO-LATERAL MYOCARDIAL INFARCTION.

(a) Due To CEREBRAL HEMORRHAGE

(b) ARTERIO SCLEROTIC + HYPERTENSIVE

(c) Due To HEART DISEASE & AURICULAR
FIBRILLATION — 2 mo.OTHER SIGNIFICANT CONDITIONS LEFT HEMIPLEGIA FROM
PREVIOUS CEREBRAL 2 mo.Was autopsy performed? No
What test confirmed diagnosis? P.K. & CLINICAL5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Myron N. King, M. D.

MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 22 PLEASANT ST. WINTHROP Date 10/13/61

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 16, 61

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St. Winthrop

Received and filed OCT 16 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED married

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Arthur Stasio
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 60 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Housewife

(Kind of work done during most of working life)

14 Industry

or Business: at home

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Italy

17 NAME OF

FATHER

Joseph DeLuca

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

Philomena Sarni

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

21

Informant

(Address) Arthur Stasio 149 Somerset Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 10/16/61

R-301A

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SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

Suffolk

Winthrop

(City or Town)

No. 876 Shirley St.

STANDARD CERTIFICATE OF DEATH

Registered No. 202

{If death occurred in a hospital or institution,
St. give its NAME instead of street and number}

PHYSICIAN — IMPORTANT

2 FULL NAME Frederick J. Hill

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence No. 876 Shirley St.

(Usual place of abode)

{(If nonresident, give city or town and State)}

Length of stay: In place of death... years... months... days. In place of residence... years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCT 18 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19... to 19...
I last saw him alive on 19... death is said to have occurred on the date stated above, at 5:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death was due to

Due To (b) natural causes, presumably, coronary

Due To (c) occlusion, acute, due to coronary ARTERY

OTHER SIGNIFICANT CONDITIONS Heart Disease

Was autopsy performed Charles Liberman M.D.

What confirmed diagnosis? for Winthrop Board of Health

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Charles Liberman, M.D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 10/19/61

6 Winthrop Winthrop
Place of Burial or Cremation Oct 21 (City or Town) 61
DATE OF BURIAL 19...

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS East Boston

Received and filed OCT 19 1961 19...

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED or DIVORCED

10a If married, widowed, or divorced HUSBAND of Mary E. Cahill
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 Years... Months... Days If under 24 hours Hours... Minutes

13 Usual Occupation: supervisor
(Kind of work done during most of working life)

14 Industry or Business: N. E. Tel. & Tel. Co.

15 Social Security No. 011-05-0207

16 BIRTHPLACE (City) East Boston, Mass.
(State or country)

17 NAME OF FATHER Henry Hill

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Catherine Hanrahan

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass.

21 Informant Mary E. Hill
(Address) 876 Shirley St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 10/19/61

T.V.B.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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OCT 19 1961 PM

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 203

No. Winthrop Convalescent Home.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Elvira Frattaroli

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran, no
(if so specify WAR)(a) Residence. No. 521 Bennington St.
(Usual place of abode)

St. East Boston

(If nonresident, give city or town and State)

Length of stay: In place of death years 2 months 24 days. In place of residence 5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 19 - 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 28, 1961 to Oct. 19, 1961
I last saw her alive on Oct 18, 1961, death is said to
have occurred on the date stated above, at 3 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of uterine cervix

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No.

What test confirmed diagnosis? Laboratory Biopsy

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify(Signed) Charles Meloni, M. D.
CHARLES MELONI
(PRINT OR TYPE SIGNATURE)

(Address) 305 Haverhill St. E. Boston Date Oct 19 - 1961

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 21 1961

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS East Boston

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female

9 COLOR white

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)
Joseph Frattaroli
(or) WIFE of (Husband's name in full)

11 IF STILL BORN, enter that fact here.

12 AGE 62 years Months Days
If under 24 hours
Hours Minutes13 Usual Occupation: housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. C.N.E.L.

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Antonio DiPacco

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Palma Granali

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Olga Tango
(Address) Neptune Rd. E. BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

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to print or
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SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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PLACE OF DEATH

Middlesex

(County)

Medford

(City or Town)



The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Medford

(City or town making return)

Registered No. 204

No. Lawrence Mem. Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Martha E. Malone

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) no

(a) Residence. No. 777 Shirley

(Usual place of abode)

St. Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death. years months 1 days. In place of residence. 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 23 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)

Cerebral Hemorrhage

5 Accident, suicide, or homicide (specify)

Date and hour of injury

If accidental, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

(Specify type of place)

Manner of

Injury

(How did injury occur?)

Nature of

Injury

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Andrew D. Guthrie

(Address) Medford, Mass.

Date Oct 31 61

7 Holy Cross Malden

Place of Burial, or Cremation.

(City or Town)

DATE OF BURIAL Oct 26, 1961

8 NAME OF FUNERAL DIRECTOR McGlinchey Funeral Home

ADDRESS 383 Broadway, Chelsea

Received and filed

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

female

10 COLOR

white

11 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

widowed

11a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

James H. Malone

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE 71 Years Months Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

School Teacher

(Kind of work done during most of working life)

15 Industry

or Business:

Retired

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

Chelsea

Mass.

18 NAME OF

FATHER

Patrick B. Kiernan

19 BIRTHPLACE OF

FATHER (City)

Boston

(State or country)

Mass.

20 MAIDEN NAME

OF MOTHER

Catherine Kiernan

21 BIRTHPLACE OF

MOTHER (City)

Boston

(State or country)

Mass.

22

Informant

(Address)

Bertha R. Kiernan

777 Shirley St., Winthrop

TRUE COPY.

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Oct 25, 1961

19

V.B.V.



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

OCT 30 1961 AM

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48, Acts of
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print or type
er signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 205

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Bertha (Brighty)

Eliss

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No.

12 Girdlestone Rd.

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. years months 8 days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

October

24,

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from
Feb. 17, 1959, to Oct. 24, 1961I last saw her alive on October 23, 1961, death is said to
have occurred on the date stated above, at 1:50 a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive cerebral hemorrhage with right hemiplegia

(b) Generalized arteriosclerosis 2 yrs.

Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) M. Traunstein, Jr., M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Date Oct. 24, 1961

Winthrop Winthrop

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Oct. 26 1961

7 NAME OF
FUNERAL

DIRECTOR Howard S Reynolds

Winthrop, Mass

ADDRESS

Received and filed Oct. 25 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Walter Bliss

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70

11

15

If under 24 hours

Years Months Days

Hours Minutes

13 Usual

Occupation:

Clerk

(Kind of work done during most of working life)

14 Industry

or Business: Hospital record room

15 Social Security No.

034-20-9501

16 BIRTHPLACE (City)

Northbridge

(State or country)

Mass.

17 NAME OF
FATHER

Robert Brighty

18 BIRTHPLACE OF

FATHER (City)

(State or country) England

19 MAIDEN NAME

OF MOTHER Eliza Porter

20 BIRTHPLACE OF

MOTHER (City)

(State or country) England

21

Informant

(Address) Priscilla Colarusso
5 Pearl Ave. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

V.B.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



OCT 25 1961 PM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **206**

PLACE OF DEATH

Suffolk

(County)

Winthron

(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John A Orrall

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 10 Floyd Street St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, 3 years, 8 months, 8 days. In place of residence, 50 years, 0 months, 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 24, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct. 9, 1957 to Oct. 24, 1961

I last saw him alive on October 24, 1961, death is said to
have occurred on the date stated above, at 4:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of prostate

INTERVAL
BETWEEN
ONSET AND
DEATH

1 1/2 yrs

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein, Jr., M.D. M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Date Oct. 24, 1961

Winthrop 52, Mass.

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 27 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

Winthrop, Mass.

ADDRESS

Received and filed OCT 25 1961 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married

10a If married, widowed, or divorced
HUSBAND of Winifred Ives
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 8 Months 24 Days If under 24 hours
Hours Minutes

13 Usual Occupation: President
(Kind of work done during most of working life)

14 Industry or Business: Printing Co.

15 Social Security No. 023-10-9003

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER George Orrall

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country)

19 MAIDEN NAME OF MOTHER Christine Sissler

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)

21 Informant Winifred Orrall
(Address) 10 Floyd St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial, or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

R-301A

CTIONS
OR
CERTIFICATE

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F DEATH

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Chapter 137,
54, requires
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48, Acts of
quires Physi-
print or type
er signature.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



OCT 25 1961 PM

COPY OF CERTIFICATE OF DEATH

207

CERTIFICATE OF DEATH

STATE OF NEW HAMPSHIRE

TOWN OR CITY
CLERK'S NO.

845

1. NAME OF DECEASED (TYPE OR PRINT) William J. Sullivan			2. DATE OF DEATH 10/25/61		
3. PLACE OF DEATH A. COUNTY Hillsborough			4. USUAL RESIDENCE (WHERE DECEASED LIVED, IF INSTITUTION: RESIDENCE BEFORE ADMISSION.) A. STATE Mass. B. COUNTY Suffolk		
B. CITY OR TOWN Manchester		C. LENGTH OF STAY (IN THIS PLACE)		C. CITY (GIVE ACTUAL TOWN OF RESIDENCE, NOT MAILING ADDRESS). Winthrop	
D. FULL NAME OF HOSPITAL OR INSTITUTION Sacred Heart Hospital			D. STREET (IF RURAL, GIVE LOCATION) ADDRESS 42 Belcher St.		E. IS RESIDENCE ON FARM? YES ☐ NO ☒
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☒ DIVORCED ☐ NEVER MARRIED ☐ WIDOWED ☐		8. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE) Mildred F. McCarthy	
9. DATE OF BIRTH 9/7/02	10. AGE (IN YEARS LAST BIRTHDAY) 59	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	11A. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Salesman - Sav. Prod. Co.	11B. KIND OF BUSINESS OR INDUSTRY
12. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) East Boston, Mass.		13. CITIZEN OF WHAT COUNTRY? USA		14. FATHER'S NAME John J. Sullivan	
15. MOTHER'S MAIDEN NAME Mary A. Green			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES OF SERVICE) No		17. SOC. SEC. NO.
18A. INFORMANT John Sullivan			18B. ADDRESS 42 Belcher St. Winthrop, Mass.		
19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) Coronary thrombosis					INTERVAL BETWEEN ONSET AND DEATH Sudden
22. I attended the deceased from to and last saw her/him alive on Death occurred at 6:15P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
23A. SIGNATURE L. D. Lavoie, Med. Ref.		(DEGREE OR TITLE)		23B. ADDRESS Manchester, N. H.	23C. DATE SIGNED 10/25/61
24A. BURIAL ☒ CREMATION ☐ ENTOMBMENT ☐ REMOVAL ☐	24B. DATE 10/30/61	24C. NAME OF CEMETERY OR CREMATORY Winthrop Cem.		24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass.	
IF ENTOMBED 24E. PLACE OF BURIAL		(NAME OF CEMETERY)		LOCATION (CITY, TOWN, COUNTY) (STATE)	DATE
25. FUNERAL DIRECTOR'S SIGNATURE A. Maley, Winthrop, Mass.		ADDRESS		COUNTERSIGNED-AGENT (CITY BO. OF HEALTH) James J. Powers, M.D.	DATE 10/27/61
DATE REC'D BY TOWN OR CITY CLERK 10/27/61		CLERK'S OWN SIGNATURE M. J. Quinn		CLERK OF Manchester, N. H.	

A true copy, Attest: Clerk of Manchester Dated 11/8/61

V.B.V.

RECEIVED



NOV 9 1961 AM

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No.

MOUNT'S CONVALESCENT HOME

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

FRANCES

BONNEY

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No.

189 Brooks St.

(Usual place of abode)

St.

East Boston

(If nonresident, give city or town and State)

Length of stay: In place of death 4 years 10 months 21 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

OCTOBER 28, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from FEB 8, 1956, to OCT 28, 1961.

I last saw her alive on OCT 28, 1961, death is said to have occurred on the date stated above, at 12:45 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC FAILURE
MYOCARDITISDue To (b) ARTERIOSCLEROTIC
HEART DISEASE

Due To (c) BRONCHOPNEUMONIA

OTHER SIGNIFICANT CONDITIONS

PAGETS DISEASE
OF BONES

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed)

A. N. Caplan MD
(PRINT OR TYPE SIGNATURE)

M. D.

(Address) 166 BRIDGEMAN ST. Date 10-28-1961

6 Woodlawn Everett
Place of Burial or Cremation Nov. 1 (City or Town) 61

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Frederick J. McGrath

ADDRESS 325 Chelsea St. E. Boston

Received and filed

OCT 31 1961

19

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No.

208

To be filed for burial permit
with Board of Health
or its Agent.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Calvin Bonney

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 76

Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

housework

(Kind of work done during most of working life)

14 Industry
or Business:

own home

15 Social Security No.

16 BIRTHPLACE (City)
(State or country)

Gloucester

Mass.

17 NAME OF
FATHER

Ruben Cahoon

18 BIRTHPLACE OF

FATHER (City)

Nova Scotia

(State or country)

19 MAIDEN NAME

Mary A. Forbes

OF MOTHER

20 BIRTHPLACE OF

MOTHER (City)

Nova Scotia

(State or country)

21

Informant

(Address)

Gladys Dowe

189 Brooks St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

OCT 31 1961 TH

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 209

PLACE OF DEATH

(County) Winthrop
(City or Town)

No. 117th Shore Drive St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Leonard Glaser (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 117th Shore Drive St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 23 years months days. In place of residence 23 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 28 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19 to 19.

I last saw him alive on 19, death is said to have occurred on the date stated above, at 2:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes, probably due to acute coronary occlusion

(b) Due to due to hypertensive coronary artery heart disease

(c) OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Charles Liberman M.D.

Was autopsy performed? What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) CHARLES LIBERMAN M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 10/28/1961

6 Place of Burial or Cremation T. Brooks St. Winthrop, Mass. (City or Town) DATE OF BURIAL Oct. 29 1961

7 NAME OF FUNERAL DIRECTOR T.B.F. funeral Service, Inc. ADDRESS Washington Ave. Chelsea

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word) MARRIED Widowed or DIVORCED

10a If married, widowed, or divorced HUSBAND of Lena Weinstein (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Watch maker (Kind of work done during most of working life)

14 Industry or Business: Jewelry Store

15 Social Security No. Not Available 011-26-9657

16 BIRTHPLACE (City) (State or country) Russia

17 NAME OF FATHER Levy O'LASER

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Levy

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant (Address) Dr. George Glaser (SON) Daman Rd. Medford

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

R-301A

CATIONS
OR
CERTIFICATE

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signature.

30 1961

9-925686

SPACE FOR ADDITIONAL INFORMATION

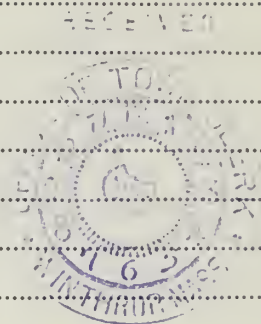
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



RULES OF PRACTICE

OCT 30 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 218

Suffolk

(County)

Winthrop

(City or Town)

Nowinthrop Community Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Agnes Theall
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran.
if so specify WAR) NO(a) Residence. No. 83 Woodside Av. Winthrop Mass
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. years. month 27 days. In place of residence. 17 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 31. 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
10-4-61, 1961, to 10-31-1961.
I last saw h. alive on 10-31-1961, death is said to
have occurred on the date stated above, at 6:30 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive Heart Failure

Due To (b) Hypertensive Heart disease

Due To (c) Cerebral Hemorrhage

3 Weeks

OTHER
SIGNIFICANT
CONDITIONS Left Hemiplegia

3 Weeks

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) A. N. Caplan, M.D.

A. N. CAPLAN, M.D.
(PRINT OR TYPE SIGNATURE)(Address) 100 PRINCETON ST. Date 10-31-1961
EAST BOSTON MASS

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS

Received and filed 11-2-1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED widowed
WIDOWED or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Charles Edwin Theall
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 10 Months 21 Days If under 24 hours
Hours Minutes13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: own home

Social Security No. 032-03-3932-D

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Patrick Sweeney

18 BIRTHPLACE OF FATHER (City) County Cork
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Margaret Kelley

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Massachusetts21 Informant Miss. Loria Theall
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 11/2/61

V.B.V.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

NOV - 2 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

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CERTIFICATEiving
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54, requires
to print or
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8, Acts of
ires Physi-
int or type
signature.

PLACE OF DEATH

Suffolk
(County)
Brighton
(City or Town)

No. St. Elizabeth's Hospital

2 FULL NAME

Baby Boy

(First Name)

(Middle Name)

Williams

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No.

85 Shore Drive

St.

Winthrop

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. 0 years 0 months 2 days. In place of residence. years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHAugust 13, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
August 12, 1961, to August 13, 1961I last saw him alive on August 13, 1961, death is said to
have occurred on the date stated above, at 12:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity Atelectasis

INTERVAL
BETWEEN
ONSET AND
DEATHDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

William L. Babaian
William L. Babaian

M. D.

(Address)

c/o St. Eliz. Hosp. Date August 13, 1961

6 Mr. Benedict Wistbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL

August 18, 1961

7 NAME OF
FUNERAL DIRECTOR

J. F. Sullivan (Wagon)

ADDRESS

360 Market St. Brighton

Received and filed

AUG 22 1961

Charles H. Inacke

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent

Registered No.

117841

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran.
If so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

W

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED SINGLE

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

1 day 7 hrs. 7 days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

(Kind of work done during most of working life)

14 Industry

or Business:

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

17 NAME OF

FATHER

David Williams

18 BIRTHPLACE OF

FATHER (City)

Boston, Mass.

(State or country)

19 MAIDEN NAME

OF MOTHER

Mary Johnson

20 BIRTHPLACE OF

MOTHER (City)

Framingham, Mass.

(State or country)

21

Informant

(Address)

St. Elizabeth's Hospital
BrightonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

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DEATH

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or failure,
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or compli-
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tion given

chapter 137,
54, requires
to print or
cause or
death on
ificates, and
8, Acts of
ires Physi-
int or type
signature.

27 1961

PLACE OF DEATH

Suffolk
(County)
Boston
(City or Town)

No.

BOSTON CITY HOSPITAL

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent

Registered No.

197821

2 FULL NAME

Grace Loring

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
{ U. S. War Veteran,
{ if so specify WAR)

(a) Residence. No.
(Usual place of abode)

329 Pleasant Street

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death. . . years. . . months. . . days. In place of residence. . . years. . . months. . . days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 17 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Aug. 14, 1961, to August 17, 1961

1 death is said to
have occurred on the date stated above, at 10:15 AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Bronchopneumonia

(a) Due to (b) Cachexia 1 to 2 years

Due to (c) Reticulum cell sarcoma, generalized

OTHER SIGNIFICANT CONDITIONS 2 to 3 years

Was autopsy performed? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M. WINTHROP O'CONNELL M.D.

(PRINT OR TYPE SIGNATURE)
BOSTON CITY HOSPITAL AUGUST 17 1961

6 Place of Burial or Cremation Woodlawn Cemetery Everett Mass

DATE OF BURIAL August 19 1961

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed AUG 22 1961

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE MARRIED (write the word)
WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of

(or) WIFE of George Loring
(Give maiden name of wife in full)
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 11 Months 6 Days If under 24 hours
Hours Minutes

Occupation: retired Executive
(Kind of work done during most of working life)

Industry or Business: Burdett College

13 Social Security No. 022-10-5890

16 BIRTHPLACE (City) Winthrop
(State or country) Mass

17 NAME OF FATHER Herbert Wendell

18 BIRTHPLACE OF FATHER (City) Winthrop
(State or country) Mass

19 MAIDEN NAME OF MOTHER Loring Emma Love

20 BIRTHPLACE OF MOTHER (City) Southport
(State or country) Maine

21 Informant (Address) Mabel T. Williams
329 Pleasant St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

07907

STANDARD
CERTIFICATE OF DEATH

Registered No.

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John L. Driscoll

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)((Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 28 Pico Avenue,
(Usual place of abode)St. Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 20 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY That deceased died on
Aug. 18 1961, at 12:35a.m., death is said to
have occurred on the date stated above, at 12:35a.m.INTERVAL
BETWEEN
ONSET AND
DEATH
2 da

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Basilar Artery Occlusion

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Diabetes Mellitus

8 y

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles L. Clay, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Aug. 20, 1961

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 23, 1961

7 NAME OF FUNERAL DIRECTOR Frederick J. McGrath

ADDRESS East Boston

Received and filed AUG 23 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED married
WIDOWED
or DIVORCED

male white

10a If married, widowed or divorced
HUSBAND of Margaret O'Donnell
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

AGE 69 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Purchasing Agent
(Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No. 013-45-3845

16 BIRTHPLACE (City) East Boston
(State or country) MASS.

17 NAME OF FATHER Florence Driscoll

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Julia Burke

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Margaret Driscoll
(Address) 28 Pico Ave. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
issued with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

A 19233
(Official Designation)Aug 21, 1961
(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

X
PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit
with Board of Health
or its Agent.

198063

Registered No. _____

No. 87 Faywood Avenue, East Boston

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME FRANK L HEALY

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR) No

(a) Residence No. 18 Tileston Road,

St. Winthrop, Massachusetts

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death _____ years _____ months _____ days. In place of residence 30 years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary occlusion

5 Accident, suicide, or homicide (specify)

Date and hour of injury _____ 19 _____

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

(Specify type of place)

Manner of

Injury

(How did injury occur?)

Nature of

Injury

While at work? _____ Was autopsy per _____ No.

6 Was disease or injury in any way related to death? _____

If so, _____

(Signed)

Michael A. Luongo

(Print or Type name)

(Address) Boston Date 8/26 1961

7 Winthrop Cem. Winthrop Mass

Place of Burial, or Cremation.

(City or Town)

DATE OF BURIAL August 29 1961

8 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St. E.B.

Received and filed AUG 29 1961

Charles W. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)

Male White Married

11a If married, widowed, or divorced, HUSBAND of Doris E. (Schwarz)

(Give maiden name of wife in full)

(or) WIFE of _____ (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 58 years 1 month 3 days If under 24 hours _____ Hours _____ Minutes

14 Usual Occupation Sales Manager (Kind of work done during most of working life)

15 Industry or Business Morrell Meat Packers

Social Security No. 013-01-3076

17 BIRTHPLACE (City) East Boston (State or country)

18 NAME OF FATHER Joseph T. Healy

19 BIRTHPLACE OF FATHER (City) New Jersey (State or country)

20 MAIDEN NAME OF MOTHER Lillian Tanner

21 BIRTHPLACE OF MOTHER (City) East Boston (State or country)

22 Informant Mrs. Doris E. Healy (Address) 18 Tileston Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

Official Designation

(Date of Issue of Permit)

Information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 48, §§ 9, 10; Chap. 114, §§ 41-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-6-50-9281/5

27 1961

7 V/R

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

OUT OF TOWN

PLACE OF DEATH

Suffolk:

(County)

Boston

(City or Town)

No. Veterans Administration HospitalJOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Healthor 9/15Registered No. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) WVI

2 FULL NAME

Raymond

PUCILLO

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 25 Wadsworth Ave.
(Usual place of abode)Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death 0 years 0 months 3 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

September 13

1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from
Sept. 5, 1961, to Sept. 13, 1961deceased is said to
have occurred on the date stated above, at 1:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

Due To

(b) Right lower lobe pneumonia

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? YesWhat test confirmed diagnosis? Autopsical clinical finding

5 Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) George Fresh

(PRINT OR TYPE SIGNATURE)

(Address) VAH, Boston, Mass. Date Sept. 13, 19616 Winthrop Cem., Winthrop, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Sept. 16

61

7 NAME OF
FUNERAL DIRECTORJoseph Longone, Jr.ADDRESS 58 Merrimac St., Boston, Mass.

Received and filed

SEP 15 1961

R.19.

Charles A. Mack

(far)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED Widowed
WIDOWED
or DIVORCED10a If married, widowed or divorced
HUSBAND of Maria La Corte

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 73 Years 7 Months 11 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: cheese makerRetired
(Kind of work done during most of working life)

14 Industry

or Business: Self Employed15 Social Security No. 1021-26-8206

16 BIRTHPLACE (City)

(State or country)

Italy17 NAME OF
FATHER Ciriaco Pucillo

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER Maria Berasso

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

21

Informant V. A. Hospital Records, 150 S.(Address) Huntington Ave., Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Guacelene Dorate

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 9/14/61

A TRUE COPY ATTEST:

Charles H. Mack

City Registrar

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)

No. Veterans Administration Hospital

2 FULL NAME . . . SAMUEL ABRAMSON

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No. 24 Dolphin Avenue
(Usual place of abode)(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR; II

Length of stay: In place of death . . . years . . . months . . . days . . . In place of residence . . . life . . . years . . . months . . . days . . .

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 17 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
September 17, 1961, to September 17, 1961deceased died at . . . death is said to
have occurred on the date stated above, at 5:00 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Subarachnoid hemorrhage.

Due To
(b) Diabetes.Due To
(c) Coronary Artery Disease.OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) . . . HARVEY L. LAMM, M. D.
(PRINT OR TYPE SIGNATURE)

(Address) VAH Boston, Mass. Date . . . 17 19 61

6 Tifereth Israel of Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 18 19 61

7 NAME OF FUNERAL DIRECTOR Sholem Memorial Chapel
ARNOLD GULOV 1668 Beacon St.

ADDRESS Brookline, Mass.

Received and filed . . . 19 . . .
Charles H. Lamm (Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 08819

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR; IIWinthrop, Mass.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED, WIDOWED, or DIVORCED10a If married, widowed, or divorced
HUSBAND of Rose Aloff
(Give maiden name of wife in full)
(or) WIFE of . . . (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 1.8 years 1 Months 1 Days If under 24 hours
Hours Minutes13 Usual Occupation: Pharmacist
(Kind of work done during most of working life)

14 Industry or Business: BISHOP DRUG Boston

15 Social Security No. 010-03-3996

16 BIRTHPLACE (City) Lynn
(State or country) Massachusetts

17 NAME OF FATHER Morris Abramson

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Eva Shanker

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant VA Hospital Records, 150 South
(Address) Huntington Ave., Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health of other)

2853 9/18
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

MR-301A

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C DEATH

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e. It means
or compli-
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rise to
(a),
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his contrib-
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ation given

go.

chapter 137,
14, requires
a to print or
cause or
e death on
ificates, and
1, Acts of
res Physi-
int or type
signature.

Section
only
nk.

27 1961
-145

X
PLACE OF DEATH
1

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

The Commonwealth of Massachusetts



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 110051

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Giovanni Freccero

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence, No. 39 Grovers Avenue
(Usual place of abode)

St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 25 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
September 24 61 to September 25 61
I last saw him on September 25 61, death is said to
have occurred on the date stated above, at 11:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MULTIPLE PULMONARY EMBOLISM

Due To

(b) CORONARY HEART DISEASE

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? YES

What test confirmed diagnosis? AUTOPSY

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Charles L. Gray, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Acc't Dir., Mass. Gen'l. Hosp. Date Sept. 25, 61

6 St. Michael Cemetery
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 25 1961

7 NAME OF FUNERAL DIRECTOR Joseph A. McNamee

ADDRESS 58 Merrimack St. Boston

Received and filed SEP 28 1961

Charles A. Inack (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: 2nd Chief (Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 012-07-5170

16 BIRTHPLACE (City) (State or country) Genoa Italy

17 NAME OF FATHER Lawrence Freccero

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Catharine Dabova

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant (Address) Mary DiGiuseppe

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other) Jacqueline D'Amico

(Official Designation) (Date of Issue of Permit) 9/26/61

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT-OF-TOWN

To be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk
(County)Dorchester Mass.
(City or Town)

No.

CARNEY Hospital

STANDARD
CERTIFICATE OF DEATH

Registered No. 09170

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Mrs. Minerva Stolpe

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U S War Veteran,
if so specify WAR)(a) Residence, No.
(Usual place of abode)

80 Prospect Ave

St.

WINTHROP

(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT 27, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Sept 27, 1961 to Sept 27, 1961I last saw him alive on Sept 27, 1961, death is said to
have occurred on the date stated above, at 2:15 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction

Due To

(b) ARTERIOCLEROTIC Ht. Disease

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

No

What test confirmed diagnosis?

EKG

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Doreen N. Belygian

M. D.

(PRINT OR TYPE SIGNATURE)

(Address)

CARNEY Hospital

6

WINTHROP - WINTHROP
Place of Burial or Cremation

DATE OF BURIAL

Sept. 30, 1961

7 NAME OF
FUNERAL DIRECTOR

Howard S. Reynolds

ADDRESS

WINTHROP, MASS.

Received and filed

OCT 3 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female White

MARRIED
WIDOWED
OR DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

ALBERT V. Stolpe

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 70 Years

1 Months

12 Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

House Wife

(Kind of work done during most of working life)

14 Industry

or Business:

OWN HOME

15 Social Security No.

NONE

16 BIRTHPLACE (City)

(State or country)

ST. JOHN

NEWFOUNDLAND

17 NAME OF
FATHER

PATRICK SCOTT

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Newfoundland

19 MAIDEN NAME

OF MOTHER

Elizabeth Condy

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Newfoundland

21

Informant

(Address)

ALBERT V. Stolpe

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Jacqueline Dorato

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

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A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

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The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

SUFFOLK

(County)

BOSTON

(City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL

STANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

1961

Registered No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME HARRIET M. CLARSON

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No.

(Usual place of abode)

42 Atlantic St.

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 5 days. In place of residence 30 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 1, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from

Sept 26, 1961 to Oct 1, 1961

I last saw him alive on Oct 1, 1961, death is said to

have occurred on the date stated above, at 3:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia

Due To

(b) Malignant lymphoma-Hodgkin's

Due To

(c) type

arterio-sclerotic cardio

vascular disease 20 yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Charles L. Cleary, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct 1, 1961

6 Holy Cross Cemetery, Malden, Mass

Place of burial or Cremation

(City or Town)

DATE OF BURIAL October 4, 1961

7 NAME OF

FUNERAL DIRECTOR

Arthur J. O'Maley

ADDRESS

Winthrop, Mass

Received and filed

Oct 4 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED

WIDOWED

or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of George J. Clarson

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 71 Years

Months

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

Housewife

(Kind of work done during most of working life)

14 Industry

or Business:

Own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

17 NAME OF

FATHER

Johnston McDermott

18 BIRTHPLACE OF

FATHER (City)

Boston

(State or country)

Massachusetts

19 MAIDEN NAME

OF MOTHER

Mary E. Calhoun

20 BIRTHPLACE OF

MOTHER (City)

Boston

(State or country)

Massachusetts

21

Informant

(Address)

Sylvia McDermott

42 Atlantic St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

MR-301A

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Washington
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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 101284

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)Margaret
2 FULL NAME

Isabelle McKinnon

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a

{U. S. War Veteran.

No

{if so specify WAR)

(a) Residence No. 34 Pleasant Street St Winthrop, Massachusetts
(Usual place of abode) (If non-resident, give city or town and State)

Length of stay. In place of death. years months 10 days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 3 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Sept 23 61 to Oct 3 61
er October 3 19 61
I last saw him alive on Oct 3 19 61, death is said to
have occurred on the date stated above, at 1:40pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

INTERNAL
BETWEEN
ONSET AND
DEATH

3 days

(b) Due To Perforated Carcinoma of
Colon

(c) Due To

OTHER SIGNIFICANT CONDITIONS Metastatic Canceroma
of lung (LUNG)

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Charles L. Clay, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct 3 19 61

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 6, 19 61

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed

Charles L. MacKay
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Single10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Clerk
(Kind of work done during most of working life)

14 Industry or Business: Stock broker

15 Social Security No. 010-07-1265

16 BIRTHPLACE (City) Nova Scotia
(State or country)

17 NAME OF FATHER Dougal MacKinnon

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Margaret MacEachern

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant Arthur J. O'Maley
(Address) 79 Atlantic St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

3927
(Official Designation)10/15/61
(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

221

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

2516

Registered No.

PLACE OF DEATH

Worcester
(County)

Worcester

(City or Town)
Worcester Nursing Home
No. 116 Houghton St.STANDARD
CERTIFICATE OF DEATH{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ANNA (Hutchinson) MAW
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 73 Chester St. Ave. St. Winthrop, Mass.
(Usual place of abode)
(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 29 61
(Month) (Day) (Year)4 I HEREBY CERTIFY That attended deceased from
Sept 17, 1961, to Oct 29, 1961
I last saw her alive on Oct 27, 1961, death is said to
have occurred on the date stated above, at 7:12 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Stomach

Due To (b) Carcinoma of liver secondary 4mths
(c) to a.OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Clinical Findings5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Joseph P. Hurley, M. D.
Joseph P. HURLEY
(PRINT OR TYPE SIGNATURE)
(Address) 390 M. H. St. Date 10/29/616 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 1, 1961

7 NAME OF FUNERAL DIRECTOR Albert B. March
174 Winthrop St.

ADDRESS Winthrop

Received and filed NOV 1 1961
Robert J. O'Keefe (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of John Maw
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 77 AGE Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 023-12-0767

16 BIRTHPLACE (City) (State or country) (East) Boston, Mass.

17 NAME OF FATHER Jonathan Hutchinson

18 BIRTHPLACE OF FATHER (City) England
(State or country)

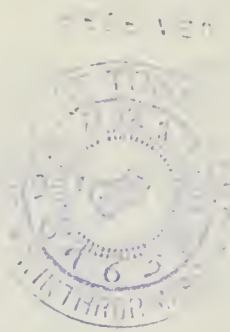
19 MAIDEN NAME OF MOTHER Ann Davis

20 BIRTHPLACE OF MOTHER (City) England
(State or country)21 Informant Mr. John Maw
(Address) 79 Walnut St. Saugus, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

ACTING CO-COMMISSIONER Oct 30 1961
(Official Designation) (Date of Issue of Permit)

Charles M. Callahan (S. H.)



NOV 14 1961 PM

A TRUE COPY AND
Robert J. La Follette
City Clerk

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

R-301A

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 000

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Israel Shuman (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No(a) Residence, No. 54 Lewis Ave. St. Winthrop Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 6 days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 2 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from Oct. 1956 to NOVEMBER 2, 1961
I last saw him live on Nov 2, 1961, death is said to have occurred on the date stated above, at 10:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Nephritis, Chronic
(b) Arteriosclerosis
(c) Due ToINTERVAL
BETWEEN
ONSET AND
DEATH2 yrs.
2 yrs.OTHER SIGNIFICANT CONDITIONS UREMIA 1 yr
Arteriosclerotic Heart Disease 1 yrWas autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Charles Liberman M.D.
CHARLES LIBERMAN, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS Date 11/21/1961

6 Place of Burial or Cremation
(City or Town)

DATE OF BURIAL Nov 3 1961

7 NAME OF FUNERAL DIRECTOR Joy Funnell Brown

ADDRESS Chelsea

Received and filed NOV 3 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WHIDOWED or DIVORCED Married

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) ENSKY

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Designer (Kind of work done during most of working life)

14 Industry or Business: Women's Clothing

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Russia

17 NAME OF FATHER Asher Shuman

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER C. B. L.

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant (Address) 54 Lewis Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 11/21/61

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
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or print or type
signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 223

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 14 Edgehill Road

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frances L. Coughlin
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 14 Edgehill Road
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months days In place of residence 60 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 3 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw h. alive on 11 P.M., 19 death is said to
have occurred on the date stated above, at 11 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To Presumably Coronary

(b) Occlusion

OTHER
SIGNIFICANT
CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no.
If so, specify

(Signed) Arthur C. Murray, M. D.

Arthur C. Murray
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop Board of Health 11-3-61

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 7 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed November 6, 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of John J. Coughlin
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. -----

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

17 NAME OF FATHER Thomas Sheffield

18 BIRTHPLACE OF FATHER (City) East Boston,
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Catherine M. Lang

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Massachusetts21 Informant John J. Coughlin
(Address) 14 Edgehill Road, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

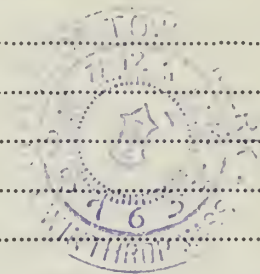
(Official Designation)

(Date of Issue of Permit) 11/6/61

V.A.

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



NOV - 6 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

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Chapter 137,
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, Acts of
gires Physi-
n or type
d signature.

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. Winthrop Community Hospital

Alfred Marasca

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 302 Maverick St.
(Usual place of abode)

Length of stay: In place of death years..... months 31 days. In place of residence..... years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 4 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from OCT 5 1961, to NOV 4 1961
I last saw h.l. alive on NOV 4 1961, death is said to have occurred on the date stated above, at 2:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) CORONARY THROMBOSIS

Due To (b) HYPERTENSIVE HEART DISEASE 3 YRS

Due To (c)

OTHER SIGNIFICANT CONDITIONS DIVERTICULITIS & PERFORATION, MCD AND HEMORRAGE
INTESTINAL OBSTRUCTION 2 WKS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL & SURGICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Charles J. Allen M. D.
362 HANOVER ST. BOSTON
(PRINT OR TYPE SIGNATURE)

(Address) Date 11/7 1961

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 7, 1961

7 NAME OF FUNERAL DIRECTOR Vincent Kapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed November 6, 1961

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 221

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, no
if so specify WAR)

East Boston, Mass.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male	9 COLOR white	10 SINGLE (write the word) MARRIED married WIDOWED or DIVORCED
------------	---------------	---

10a If married, widowed, or divorced HUSBAND of Giovannina DeVita
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years..... Months..... Days If under 24 hours
Hours..... Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: -----

15 Social Security No. 011-01-3611

16 BIRTHPLACE (City) (State or country) Italy

17 NAME OF FATHER Ferdinando Marasca

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Adelina DeFilippo

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Giovannina Marasca (wife)
(Address) 302 Maverick St., East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Ferrante
(Signature of Agent of Board of Health or other)

11/6/61
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

NOV - 6 1961

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 225

X
PLACE OF DEATHSuffolk
(County)Winthrop
(City or Town)

No. 58 Harbor View Ave.

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Frances J (Anderson) Wood

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 58 Harbor View Ave.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 40 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 4 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw him alive on 10 P. M. death is said to
have occurred on the date stated above, at 10 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Presumably

(b) Coronary Occlusion

(c) Arterio-sclerotic Heart Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray, M. D.

Arthur C. Murray
(PRINT OR TYPE SIGNATURE)

(Attest) Winthrop Board of Health 5 Nov 1961

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 8 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed November 6, 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED widow
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Clement Wood
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 6 Months 11 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 010-10-8529

16 BIRTHPLACE (City)
(State or country) Boston Mass.

17 NAME OF FATHER William J Anderson

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Louise

20 BIRTHPLACE OF MOTHER (City)
(State or country) England21 Informant Dorothy Herdt
(Address) 3 Cottage Ave. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial, or transit permit was issued:

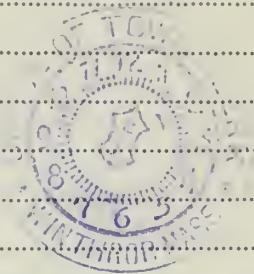
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 11/1/61

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

RECEIVED



NOV - 6 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
CERTIFICATE

CAUSE OF DEATH

enter
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condition given

Chapter 137,
137, requires
to print or
the cause or
death on
ificates, and
Acts of
quires Physi-
nt or type
signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 226

Suffolk
(County)

Winthrop
(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Elizabeth VanBuskirk (Tower)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 50 Hutchinson St.
(Usual place of abode)

St. 20
(If nonresident, give city or town and State)

Length of stay: In place of death... years... months 3 days. In place of residence... years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 5 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Nov 2, 1961, to Nov 5, 1961.
I last saw him alive on Nov 4, 1961, death is said to
have occurred on the date stated above, at 6:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE BRONCHOPNEUMONIA

INTERVAL
BETWEEN
ONSET AND
DEATH

5 DAYS

Due To (b) VIRUS INFECTION

5 DAYS

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Dorothy Cheney Appleton M. D.

DOROTHY CHENEY APPLETON
(PRINT OR TYPE SIGNATURE)

(Address) 197 Woodside Ave. Date Nov 5, 1961

WINTHROP, MASS

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 8, 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED widow
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Albert G VanBuskirk
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 4 Months 9 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 021-01-0743

16 BIRTHPLACE (City) London
(State or country) New Brunswick

17 NAME OF FATHER John Tower

18 BIRTHPLACE OF FATHER (City) New Brunswick
(State or country)

19 MAIDEN NAME OF MOTHER Eliza Kelly

20 BIRTHPLACE OF MOTHER (City) New Brunswick
(State or country)

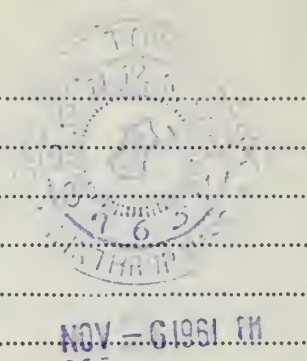
21 Informant Albert G VanBuskirk
(Address) 20 Beacon St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 11/6/61

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

No. 66 Winthrop Shore Drive

STANDARD
CERTIFICATE OF DEATH

Registered No. 227

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marietta (White) Moore

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 66 Winthrop Shore Drive
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 5 years months days. In place of residence 72 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 18 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct. 1955, to Nov 18 1961

I last saw her alive on 11/16 1961, death is said to
have occurred on the date stated above, at 7:40 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCIDENT

INTERVAL
BETWEEN
ONSET AND
DEATH
7 DAYS

Due To (b) GENERAL ARTERIOSCLEROSIS AND
ARTERIO-SCLEROTIC HEART DISEASE

6 YRS.

Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased NO
If so, specify

(Signed) Myron N. King M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 22 Pleasant St. Winthrop Date 11/18 1961

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov. 21 1961

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds
ADDRESS Winthrop Mass

Received and filed NOV 20 1961 19. (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widow

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Edwin L. Moore (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 93 Years 11 Months 2 Days If under 24 hours Hours Minutes

13 Usual Occupation: None (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Ashburnham (State or country) Mass

17 NAME OF FATHER Charles H. White

18 BIRTHPLACE OF FATHER (City) Ashburnham

(State or country) Mass

19 MAIDEN NAME OF MOTHER Florence H.

20 BIRTHPLACE OF MOTHER (City) Ashburnham

(State or country) Mass

21 Informant O.A.A. Records

(Address) Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 11.20.61

CTIONS
R
L CERTIFICATE

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F DEATH

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ditions contrib-
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to be terminal
condition given

CCI

Chapter 137,
151, requires
to print or
the cause or
of death on
ificates, and
Acts of
quires Physi-
nt or type
nd signature.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 1961 AM

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 5 Edge Hill Rd.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 228

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Dr. George H. Schwartz

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, WW I
if so specify WAR)

(a) Residence. No. 5 Edge Hill Rd.

(Usual place of abode)

St. Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death 20 years.....months.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 18 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw h..... alive on....., 19....., death is said to
have occurred on the date stated above, at 10:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

INTERVAL
BETWEEN
ONSET AND
DEATHDue To Presumably Coronary Occlusion
(b) suddenDue To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? post-mortem judgement5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Arthur C. Murray, M. D.

Arthur C. Murray
(PRINT OR TYPE SIGNATURE)
Winthrop Board of Health 18 Nov 19616 Ohel Jacob Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 20 1961

7 NAME OF FUNERAL DIRECTOR Paul B. Levine
ADDRESS 470 Harvard St., Brookline

Received and filed November 20 1961

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Single
or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: Physician
(Kind of work done during most of working life)

14 Industry or Business: Medicine

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country)

17 NAME OF FATHER Benjamin M. Schwartz

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Annie Baron

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Mrs. Ida Miller
(Address) 28 Converse Ave., NewtonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 5-31-18

DATE OF DISCHARGE..... 5-27-19

RANK, RATING..... 1ST LT

ORGANIZATION AND OUTFIT..... Medical Corps

SERVICE NUMBER..... - 1111

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 1901 AM

PLACE OF DEATH

Suffolk
(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 229

(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Jacobson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, Y
(if so specify WAR)

(a) Residence. No. 162 Endicott Ave., Revere, Mass. St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death... 0 years... 0 months... 3 days. In place of residence... 10 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November, 19, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov. 17, 19. 61, to Nov. 19, 19. 61I last saw her alive on Nov. 19, 19. 61, death is said to
have occurred on the date stated above, at 10.00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Infarction

INTERVAL
BETWEEN
ONSET AND
DEATH

3 Days

Due To (b) Coronary Occlusion

3 Days

Due To (c) Coronary Artery Disease

2 Years

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus Few Years

Was autopsy performed? No

What test confirmed diagnosis? Electrocardiogram

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John F. Collins, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Revere, Mass. Date Nov. 19, 1961

6 Reylston Lodge Mem. Park Baker St.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL W. Rox. Nov. 20 19 61

7 NAME OF FUNERAL DIRECTOR Schlossberg Fun. Ser.

ADDRESS 1257 Blue Hill Ave. Matt.

Received and filed NOV 20 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Bernard Jacobson
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years... Months... Days If under 24 hours
Hours... Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Ephram Winer

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Bluma Levine

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Bernard Jacobson
(Address) 162 Endicott Ave. BeachmontI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other)
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE *

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 1961 AM

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

Jason

Edward Heath

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. ~~300 Bedford Street~~

(Usual place of abode)

32 Marshall

St.

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months 16 days. In place of residence, 30 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 23 1961

(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from November 7, 1961, to November 23, 1961

I last saw him alive on November 22, 1961, death is said to have occurred on the date stated above, at 8:12 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

Due To (b) arteriosclerosis

generalized

Due To (c) senility

OTHER SIGNIFICANT CONDITIONS Perforated peptic ulcers - postop.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph B. Marshall M. D.

Joseph B. Marshall

(PRINT OR TYPE SIGNATURE)

(Address) 194 Washington Ave. Date 1/24/61

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 25, 1961

7 NAME OF FUNERAL DIRECTOR

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed November 24, 1961

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 230

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)}

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED married WIDOWED or DIVORCED

10a If married, widowed, or divorced HUSBAND of Edna Augusta May Leonard (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 11 Months 8 Days If under 24 hours Hours Minutes

13 Usual Occupation: salesman (Kind of work done during most of working life)

14 Industry or Business: retail Oil Co.

15 Social Security No. 025-01-0439

16 BIRTHPLACE (City) (State or country) Quebec

17 NAME OF FATHER Jason Heath

18 BIRTHPLACE OF FATHER (City) (State or country) Quebec
Thurzah LeClair19 MAIDEN NAME OF MOTHER Paris, France
Quebec20 BIRTHPLACE OF MOTHER (City) (State or country) Mrs. Edward J. Heath
32 Marshall St. Winthrop

Informant (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

(Registrar)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop Mass

(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No. 231

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie (Phillips) Goldman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 14 Trident Ave., Winthrop Mass
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 23 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 28 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Nov. 19.46 to Nov. 28 1961
I last saw her alive on Nov. 28 1961, death is said to
have occurred on the date stated above, at 8:10 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastro Intestinal Hemorrhage

Due To Duodenal Ulcer, Chronic

(b) ~~Chronic~~

Due To Duodenal Ulcer, bleeding

(c) ~~Chronic~~

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass Date 11/28/1961

6 Place of Burial or Cremation
DATE OF BURIAL Nov 28 1961

7 NAME OF FUNERAL DIRECTOR TRF Funeral Service Inc.
ADDRESS 151 Washington Ave Chelsea

Received and filed NOV 28 1961

INTERVAL
BETWEEN
ONSET AND
DEATH
24 hrs.

25 yrs.

3 wks.

5 yrs.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEM 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of MAX GOLDMAN
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation CAT Home
(Kind of work done during most of working life)

14 Industry or Business HOUSEWIFE

15 Social Security No. None

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER ABRAHAM PHILIPS

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Rose PALAIS

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant MORRIS SANDLER, Brooklyn
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

(Registrar)

MR-301A

CTIONS
R
CERTIFICATE

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DEATH

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Chapter 137,
19, requires
amo print or
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of death on
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nt or type
designature.

RECEIVED



SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

NOV 28 1961 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

B.-THIS IS A
PERMANENT RECORD.
Use only

WHITE APPROVED
black ink or black
newspaper ribbon.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

In giving
STATE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

This does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
cation which caused
it.

Conditions, if any,
which gave rise to
be cause (a),
causing the under-
lying cause last.

Conditions contrib-
uting to death but not
at the terminal
condition given

Chapter 137,
1954, requires
physicians to print or
write the cause or
causes of death on
all certificates.

CHAPTER 46, §§ 9 &
CHAPTER 114, §§ 45,
(CHAPTER 38, § 6.)

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 232

No. Mount's Convalescent Home

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Highland Avenue John A Chase
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 6 Garfield Avenue
(Usual place of abode)

St. Revere Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death years months 3 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 29 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov. 20, 1961 to Nov. 30, 1961

I last saw him alive on Nov. 29, 1961, death is said to
have occurred on the date stated above, at 5-8 m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

Due To (b) Arteriosclerosis

Due To (c) C.A.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) [Signature] M. D.
(Address) [Address] Date 3-27-61 1961

6 Woodlawn Cemetery Everett Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 31, 1961

7 NAME OF FUNERAL DIRECTOR William J. Killion
ADDRESS 1 Sprague St. Revere Mass.

Received and filed [Signature] 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Mary Stone
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 7 Months 12 Days If under 24 hours
Hours Minutes

13 Usual Occupation: conductor
(Kind of work done during most of working life)

14 Industry or Business: Rail road

15 Social Security No. 023-07-1615

16 BIRTHPLACE (City) Lynn, Mass.
(State or country)

17 NAME OF FATHER Edward F. Chase

18 BIRTHPLACE OF FATHER (City) Lynn, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Ann Clifford

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Mrs John Chase
(Address) 6 Garfield Ave, Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RECEIVED



RULES OF PRACTICE

The fulfillment of the purpose of these laws is for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 003

PLACE OF DEATH

1

Suffolk
(County)

Wintrop
(City or Town)

No. 457 Shirley St

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME

Lena Shapiro

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR) M

(a) Residence. No.

457 Shirley

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 28 years months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 30 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov 30 to Nov 30 1961
I last saw him alive on Nov 29 1961, death is said to
have occurred on the date stated above, at 5 p. m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) congestive heart failure

Due To (b) Rheumatic heart disease 15 years

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signed) H. D. Greenfield, M. D.
(PRINT OR TYPE SIGNATURE)

(Address) 411 Green St Date 11-30-1961

6 Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec 1 1961

7 NAME OF FUNERAL DIRECTOR Joseph J. Shapiro
ADDRESS Chelsea

Received and filed Dec 1 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE MARRIED (write the word)
WIDOWED MARRIED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Joseph S. Shapiro
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. 01-2-200-2329

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Louis Silverman

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Lily E. S. S.

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Joseph S. Shapiro
(Address) 457 Shirley St

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

M R-301A

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

1. Giving
OF DEATH

2. Not enter
more than one
cause for each
(b) and (c)

3. Does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which caused

4. Causes, if any,
gave rise to
cause (a),
the under-
cause last.

5. Conditions contrib-
death but not
to the terminal
condition given

6. Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
nder signature.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



RULES OF PRACTICE

DEC 1 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Handwritten scribbles and signatures, including the number "2" and various illegible marks.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or Registrar

PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)

No. Veterans Administration Hospital

STANDARD
CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Joseph P FLANNERY, Sr.
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) WW I

(a) Residence No. 25 Taylor
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death years months 8 days. In place of residence 45 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 11, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct. 6, 1961 to October 11, 1961

deceased, death is said to
have occurred on the date stated above, at 11:25 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Hepatic failure 7 days with
(a) cirrhosis (hemochromatosis).

INTERVAL
BETWEEN
ONSET AND
DEATH
years

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy & clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) HENRY T. O'NEAL M. D.
(PRINT OR TYPE SIGNATURE)

(Address) VAH Boston, Mass. Date Oct. 11, 1961

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 17, 1961

7 NAME OF FUNERAL DIRECTOR O'Malley Funeral Home

ADDRESS 79 Atlantic St., Winthrop, Mass.

Received and filed Oct 17 1961
Phyllis M. Mackin (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED

10a If married, widowed or divorced
HUSBAND of Margaret McDonald
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years 6 Months 29 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Chauffeur (Retired)
(Kind of work done during most of working life)

14 Industry or Business: Boston Sand & Gravel Corp

15 Social Security No. CIO-22-8548

16 BIRTHPLACE (City) Watertown
(State or country) Mass.

17 NAME OF FATHER Owen W. Flannery

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Ferrins
Margaret Ferrins

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Veterans Administration Records
(Address) 150 S. Huntington Ave Boston Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other
4034 10/16/61
(Official Designation) (Date of Issue of Permit)

FORM R-301A

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

1. Giving

2. Not enter

3. More than one

4. One for each

5. (b) and (c)

6. Does not mean
7. Mode of dying,
8. Heart failure,
9. Etc. It means
10. Cause, or compli-
11. Which caused

12. ions, if any,
13. gave rise to
14. cause (a),
15. the under-
16. cause last.

17. Conditions contrib-
18. death but not
19. to the terminal
20. condition given

21. Chapter 137,
22. of 1954, requires
23. that to print
24. the cause
25. of death on
26. certificates, and
27. of 48, Acts of
28. requires Physi-
29. cian to print or type
30. under signature

A TRUE COPY ATTEST:

Charles W. Tenackie
City Registrar

RECEIVED



JAN 21 1962 AM

The Commonwealth of Massachusetts

235

SUFFOLK

(County)

BOSTON

(City or Town)

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 10056

No. Massachusetts General Hospital DAKER MEMORIAL

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN -- IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

2 FULL NAME Rose Corwin

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 36 Perkins Street
(Usual place of abode)

Winthrop, Massachusetts

(If nonresident, give city or town and State)

Length of stay: in place of death years months days In place of residence 40 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 23, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from
October 23, 1961 to October 23, 1961We last saw her alive on October 23, 1961, death is said to
have occurred on the date stated above, at 8:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) rupture of abd. aneurysm

Due To

(b)

atherosclerotic abd. aortic aneurysm 15 yrs

Due To

(c)

atherosclerosis, severe, yrs

OTHER SIGNIFICANT CONDITIONS hypertensive heart dis. 8 yrs

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Charles L. Cio, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir. Mass. Gen'l. Hosp. D October 24, 1961

6 Mt. Lebanon, Workmen's Circle, W.F.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 25, 1961

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St. Brookline

Received and filed OCT 26 1961

Charles L. Cio, M.D. (Signer)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED
WIDOWED
or DIVORCED Married

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Samuel Corwin

(Husband's name in full)

11 IF STILL BORN, enter that fact here.

12

AGE 81

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Housewife

Occupation:

(Kind of work done during most of working life)

14 Industry

At Home

or Business:

15 Social Security No.

None

16 BIRTHPLACE (City)

(State or country)

Hungary

17 NAME OF

FATHER

Joseph Ober

18 BIRTHPLACE OF

FATHER (City)

Hungary

(State or country)

19 MAIDEN NAME

OF MOTHER

Celia (CBL)

20 BIRTHPLACE OF

MOTHER (City)

Hungary

(State or country)

21

Informant

Samuel Corwin

(Address)

36 Perkins St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

IM R-301A

INSTRUCTIONS
FOR
AL CERTIFICATEIn giving
E OF DEATHnot enter
re than one
se for each
, (b) and (c)does not mean
of dying,
heart failure,
etc. It means
ase, or compli-
which causedtions, if any
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
of 1954, requires
ans to print or
the cause or
of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.M.C.
Director

use only

CK Ink.

NO

0-928145

A TRUE COPY ATTEST:

Charles W. Mackie

CITY REGISTER

RECEIVED



JAN 2 1962 AM

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Chelsea 236
(City or town making return)

Registered No. 526

PLACE OF DEATH

Suffolk (County)

Chelsea

No. Chelsea Naval Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Joseph Buckley
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, WWI & II
if so specify WAR)

(a) Residence. No. 170 Cliff Ave.
(Usual place of abode)

Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death years months 15 days. In place of residence years months 15 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 24, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Blunt force injury of head with fracture of skull, subdural hematomas and cerebral laceration.

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury On or about 10/8/61

If accidental, was injury causally related to the death?

Where did injury occur? Winthrop, Mass.
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Public street.
(Specify type of place)

Manner of injury Accidental fall to pavement.
(How did injury occur?)

Nature of injury

While at work? Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.

(Address) Boston, Mass. Date 10/24/61

7 Place of burial Arlington Nat'l Cem. Pt. Myer, Va.

DATE OF BURIAL Oct. 30, 1961

8 NAME OF FUNERAL DIRECTOR William E. McGinn

ADDRESS 157 Maple St., Lynn, Mass.

Received and filed DEC 12 1961

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Single

Has he married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 63 Years 5 Months 4 Days If under 24 hours Hours Minutes

14 Usual Occupation Lt. Col. USMC
(Kind of work done during most of working life)

15 Industry or Business: retired

16 Social Security No.

17 BIRTHPLACE (City) Haverhill, Mass.
(State or country)

18 NAME OF FATHER Michael Buckley

19 BIRTHPLACE OF FATHER (City) Haverhill, Mass.
(State or country)

20 MAIDEN NAME OF MOTHER Julia Greene

21 BIRTHPLACE OF MOTHER (City) Peabody, Mass.
(State or country)

22 Informant (Address) Mary Buckley
38 Forest St. Danvers, Mass.

A TRUE COPY. ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Oct. 25, 1961

THIS IS A PERMANENT RECORD



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE -- DEC 12 1961 AM

DATE OF DISCHARGE --

RANK, RATING --

ORGANIZATION AND OUTFIT --

SERVICE NUMBER --

.....

The Commonwealth of Massachusetts

237

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 10272

PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)

No. Neponset View Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN -- IMPORTANT

(Was deceased a
U. S. War Veteran. no
if so specify WAR)

2 FULL NAME Annie C. Brown

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 26 Nevada Street,
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death 3 years months days. In place of residence years months days.

INSTRUCTIONS
FOR
CERTIFICATE

In giving
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
etc. It means
cause, or compli-
s which caused

ditions, if any,
ch gave rise to
ve cause (a),
ing the under-
e cause last

conditions contrib-
to death but not
to the terminal
condition given

Chapter 132,
1954, require
ans to print or
the cause or
of death on
certificates, and
148, Acts of
eases Physi-
e print or type
under signature

M. O.
12-1982

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCT 30 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 27, 1954, to OCT 20, 1961.
I last saw her alive on OCT 20, 1961, death is said to
have occurred on the date stated above, at 5:00 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Terminal
Antecedent

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) M. O. Brown, M. D.
(PRINT OR TYPE SIGNATURE)
(Address) My address is 10/30/1961

6 David Vicor Choulm (Lebanon) W. Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 1, 1961

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon
ADDRESS 120 Harvard Street, Brookline.

Received and filed Charles M. Mac... 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED widowed

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of William Brown
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years Months Days if under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Boston,
(State or country) Mass.

17 NAME OF FATHER Harris Payser

18 BIRTHPLACE OF FATHER (City) Poland
(State or country)

19 MAIDEN NAME OF MOTHER Caroline Wilson

20 BIRTHPLACE OF MOTHER (City) Boston,
(State or country) Mass.

21 Informant Leslie Brown
(Address) 26 Nevada St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
4280 10/31/61
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie
City Registrar

RECEIVED



JAN 21 1962 AM

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No.

Massachusetts General Hospital BAKER MEMORIAL

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

10500

Registered No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Mary S. Hanlon (Schwartz)

(First Name) (Last Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
If so specify WAR)

(a) Residence No. 155 Shirley
(Usual place of abode)

St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay. In place of death. years. months. 2 days. In place of residence 30 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 6, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
November 3, 1961, to November 6, 1961.

5 I last saw her alive on November 6, 1961. Death is said to
have occurred on the date stated above, at 1:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Extension of Acute
Inferior Myocardial

Due To
(c) Acute Inferior Myocardial 3 day

OTHER Infection
SIGNIFICANT CONDITIONS Coronary artery disease

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles L. Clark, M. D.
(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Con'l. Hlth. Date Nov 6, 1961

6 Holy Cross
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 7, 1961

7 NAME OF FUNERAL DIRECTOR

ADDRESS 147 Winthrop St. Boston

Received and filed Nov 8, 1961

Charles L. Clark (Signature)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Married

10a If married, widowed, or divorced
HUSBAND of (Give maiden name if file in full)

(or) WIFE of William A. Hanlon
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 7 Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at Home

15 Social Security No.

16 BIRTHPLACE (City) Boston (State or country) Mass

17 NAME OF FATHER Simon J. Schwartz

18 BIRTHPLACE OF FATHER (City) Germany (State or country)

19 MAIDEN NAME OF MOTHER Elizabeth J. Dolan

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant William A. Hanlon
(Address) 147 Winthrop St. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

4361 11/6/61
(Official Designation) (Date of Issue of Permit)

INSTRUCTIONS
FOR
AL CERTIFICATE

In giving
E OF DEATH

not enter
more than one
cause for each
(a), (b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
which caused

itions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
do the terminal
condition given

Chapter 137,
of 1954, requires
ians to print or
the cause or
of death on
certificates, and
r 48, Acts of
quires Physi-
to print or type
under signature

Director

use only

INK

11-11-61

2. BOOK (if any) NO.:

Charles H. Jenkins
City Engineer

RECEIVED



JAN 21 1962 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-8-56-918227

1 PLACE OF DEATH

Essex
(County)

Lynn
(City or Town)

No. 94 Franklin Street

2 FULL NAME Leonora B. Madden (Boardman)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 86 Plummer Ave.
(Usual place of abode)

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death. 8 years. months. days. In place of residence. 8 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 1, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 1950, to December 1, 1961
I last saw her alive on Nov. 28/1961, death is said to have occurred on the date stated above, at 6.30 p. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular accident

Due To Hypertensive heart disease
(b) 6 yrs

Due To
(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) William Berenson M. D.

(Address) 32 So. Common St. Lynn 12/1/61

6 Vernon Grove Cem. Milford, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 5, 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed December 8, 1961

(Registrar of City or Town where deceased resided)



The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Lynn

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 239

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widow

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Edward A. (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years — Months — Days If under 24 hours Hours — Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Maine

17 NAME OF FATHER --- Boardman

18 BIRTHPLACE OF FATHER (City) (State or country) Maine

19 MAIDEN NAME OF MOTHER c/n/b/1

20 BIRTHPLACE OF MOTHER (City) (State or country) Maine

21 Informant Arthur J. O'Maley (Address) 79 Atlantic St. Winthrop

A TRUE COPY ATTEST: (Registrar of City or Town where death occurred)

DATE FILED December 4, 1961

RECEIVED



DEC 8 1961 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

No. 42 Sunnyside Ave.

STANDARD CERTIFICATE OF DEATH

Registered No. 240

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Lawrence J. Ryan Sr.
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence, No. 42 Sunnyside
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 4 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19....., to 19.....

I last saw him alive on 19....., death is said to
have occurred on the date stated above, at 19.....

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death apparently due
(b) to natural causes,
(c) presumably acute

OTHER SIGNIFICANT
CONDITIONS
Coronary occlusion,
complicated by known
diabetes.

Was autopsy performed?
What test confirmed diagnosis? Winthrop Board of Health

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles Liberman M.D.
(PRINT OR TYPE SIGNATURE)
(Address) Winthrop, Mass Date 12/4/61 19.....

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 9, 1961

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS 325 Chelsea St. E. Boston

Received and filed DEC 7 1961 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
or DIVORCED

10a If married, widowed or divorced
HUSBAND of Mary A. Riley
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation Stevedore
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 022-10-0804

16 BIRTHPLACE (City) Montreal
(State or country) Canada

17 NAME OF FATHER Patrick Ryan

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Mary A. King

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant Mary A. Ryan
(Address) 42 Sunnyside Ave

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
J. P. Liberman
(Official Designation) (Date of Issue of Permit) 12/7/61

M R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
(b) and (c)

oes not mean
le of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
condition given

Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
der signature.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

4-15-VEJ



DEC - 7 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MR-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
e for each
(b) and (c)does not mean
le of dying,
heart failure,
etc. It means
se, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
as to print or
e cause or
f death on
ificates.

50M-5-57-920345

PLACE OF DEATH

1

Suffolk

(County)

Winthrop, Mass.

(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

STANDARD

CERTIFICATE OF DEATH

Registered No. 241

No. Winthrop Convalescent Home,

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME

Frances Chiappa Ciampa

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran, no
if so specify WAR)

(a) Residence. No. 90 Grady Ct., East Boston, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years 2 months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

December 5, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

June

,

1961, to

Dec. 5,

,

1961

I last saw her alive on December 5, 1961, death is said to

have occurred on the date stated above, at 1:45 P.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac Decompensation

1 week

Due To
(b)

Hyperchronic Anemia

1 Mo.

Due To
(c)Multiple Myelomata
with metastasis

1 yr

OTHER
SIGNIFICANT
CONDITIONS

Laminectomy

9 mos

Was autopsy performed? no

What test confirmed diagnosis? Laminectomy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

A. N. Caplan M. D.

(Signed)

A. N. Caplan

M. D.

(Address)

106 Princeton St.
East Boston, Mass.

Date

12-5-61

6

Place of Burial or Cremation

St. Michael Cemetery Boston

(City or Town)

DATE OF BURIAL

December 9,

1961

7 NAME OF
FUNERAL DIRECTOR

Vincent Rapino

ADDRESS

9 Chelsea St., East Boston, Mass.

Received and filed

DEC - 8 1961

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)
MARRIED married
WIDOWED or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Samuel Ciampa

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

44

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

Housewife

(Kind of work done during most of working life)

14 Industry

or Business:

at home

15 Social Security No.

not known

16 BIRTHPLACE (City)

(State or country)

East Boston, Mass.

17 NAME OF
FATHER

Gaetano Galisano

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME
OF MOTHER

Grace Micciche

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

21

Informant

(Address)

John Ciampa (son)

90 Grady Ct., East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

X

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

. . . Chap. 114, Sec. 46, G. L., (Tercenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative helpfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

INSTRUCTIONS
FOR
VITAL CERTIFICATE

In giving
STATE OF DEATH

do not enter
more than one
cause for each
a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
mia, etc. It means
cause, or compli-
s which caused

ditions, if any,
ch gave rise to
ve cause (a),
ing the under-
g cause last.

onditions contrib-
to death but not
l to the terminal
condition given

m c.

Chapter 137,
f 1954, requires
ians to print or
the cause or
of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 212

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 74 Washington Avenue

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Lucy C. McEnaney
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 74 Washington Avenue
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 12 years.....months.....days. In place of residence 12 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 5 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at 1:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To Presumably Coronary
(b) Occlusion

sudden

Due To Arteriosclerotic Heart
(c) Disease

Years

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray, M. D.
Arthur C. Murray
(PRINT OR TYPE SIGNATURE)
Winthrop Board of Health 5 Dec 1961

6 Holy Cross, Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 7, 1961

7 NAME OF FUNERAL DIRECTOR John C. Kelly
ADDRESS 286 Meridian St., East Boston

Received and filed DEC - 6 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Single
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here. -
12 AGE 76 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: Retired Clerk
(Kind of work done during most of working life)

14 Industry or Business: Suffolk County Court

15 Social Security No. None

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF FATHER James P. McEnaney

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Lucy E. Martin

20 BIRTHPLACE OF MOTHER (City) St. John
(State or country) New Brunswick

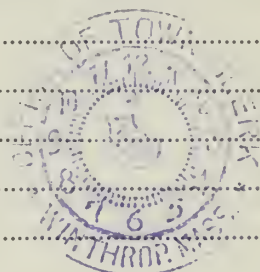
21 Informant Rose E. McEnaney
(Address) 74 Washington Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....



RULES OF PRACTICE

DEC 6 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 49 Bartlett Road

STANDARD
CERTIFICATE OF DEATH

Registered No. 213

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

2 FULL NAME Ethel M. Kelly

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NoINSTRUCTIONS
FOR
CERTIFICATE(a) Residence, No. 49 Bartlett Road
(Usual place of abode)St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 12 years months days. In place of residence 12 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 9 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw him alive on 19 death is said to
have occurred on the date stated above, at 6:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To (b) Presumably Coronary Occlusion

Due To (c) Arteriosclerotic Heart Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Arthur C. Murray, M.D.

Arthur C. Murray
(PRINT OR TYPE SIGNATURE)

Winthrop Board of Health Dec 10 1961

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 13, 1961

7 NAME OF FUNERAL DIRECTOR John C. Kelly

ADDRESS 286 Meridian St., East Boston

Received and filed DEC 12 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR white 10 SINGLE (write the word)
MARRIED, WIDOWED, or DIVORCED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of John C. Kelly
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF FATHER Nathan Bates

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Margaret O'Neil

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass.21 Informant John C. Kelly
(Address) 49 Bartlett Road, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Nathan C. Murray
(Signature of Agent of Board of Health or other)Health Officer 12/14/61
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Mayflower Nursing Home
39 Grovers Ave.

2 FULL NAME Julia Dahl (Hughes)

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No.

24 Cary Ave.

(Usual place of abode)

St. Revere

(If nonresident, give city or town and State)

Length of stay: In place of death..... 2 months..... days. In place of residence..... 5 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 10, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
MAR 10, 1938, to 12-10, 1961.I last saw him alive on DEC 7, 1961, death is said to
have occurred on the date stated above, at 10:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF BREAST

Due To

(b) CARCINOMA OF LUNGS

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical & SURGICAL

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) William P. Finnegan, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 647 Broadway Chelsea 12/10/61

6 St Josephs Cem. River Grove Illinois
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 13, 1961

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike

ADDRESS 305 Beach St. Revere 51, Mass.

Received and filed DEC 11 1961

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 214

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)}INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)oes not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which causedons, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
requires Physi-
to print or type
nder signature.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Arthur C. Dahl

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 68 Years 3 Months 25 Days If under 24 hours
Hours Minutes

13 Usual Occupation: At Home (Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. 326 - 28 - 6756

16 BIRTHPLACE (City) Chicago
(State or country) Illinois

17 NAME OF FATHER James Hughes

18 BIRTHPLACE OF FATHER (City) Albany
(State or country) New York

19 MAIDEN NAME OF MOTHER Mary Courtney

20 BIRTHPLACE OF MOTHER (City) Holyoke
(State or country) Mass.21 Informant (Address) Raymond G. Dahl
24 Cary Ave Revere, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

DEC 11 1961 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

215

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 69 Bay View Ave

STANDARD
CERTIFICATE OF DEATH

Registered No.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Lillian I (Shattuck) Felch

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)INSTRUCTIONS
FOR
CERTIFICATEIN GIVING
OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)does not mean
mode of dying,
as heart failure,
etc. It means
cause, or compli-
cation which causedconditions, if any,
which gave rise to
cause (a),
the under-
cause last.conditions contrib-
o death but not
to the terminal
condition given

M. C.

Chapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
quires Physi-
o print or type
nder signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 12 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
10 Nov 1959, to, 22 Nov 1961I last saw her alive on 22 Nov 1961, death is said to
have occurred on the date stated above, at 7:50 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To Presumably Coronary Occlusion sudden
(b)Due To Arteriosclerotic Heart Disease 5 yrs.
(c)

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus 2 yrs

Was autopsy performed? no
What test confirmed diagnosis? post mortem judgement5 Was disease or injury in any way related to occupation of deceased? no
If so, specify(Signature) Arthur C. Murray M. D.
PRINT OR TYPE SIGNATURE

Winthrop Board of Health 14 Dec 1961

Winthrop Winthrop
(City or Town)Place of Burial or Cremation
DATE OF BURIAL Dec. 16 1961

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed DEC 17 1961 19...

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED widow10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Daniel T Felch
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 0 Months 1 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 023-07-0159

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER Willard Shattuck

18 BIRTHPLACE OF FATHER (City) Westwood
(State or country) Mass

19 MAIDEN NAME OF MOTHER Harriet Renele

20 BIRTHPLACE OF MOTHER (City) Needham
(State or country) Mass21 Informant Lillian DeMoucell
(Address) Bellerica MassI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

110 (Official Designation) 12/15/61 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)

Sancta Maria Hospital

No.

Percy J. Vance

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

89 Norman Street

(a) Residence, No.

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Winthrop, Mass.

St.

No

37

years

months

days

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

December 12, 1961

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Dec. 8, 1961 to Dec. 12, 1961

I last saw him alive on Dec. 11, 1961, death is said to

have occurred on the date stated above, at 5:30a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute general peritonitis

Due To ruptured diverticula

(b)

Due To Septicemia

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Michael E. McGarty

M. D.

(Address)

520 Comm. Ave. Boston 12/12/61

Winthrop Cemetery

6 Place of Burial or Cremation

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR

Maurice J. Kirby

ADDRESS

Winthrop, Mass.

Received and filed

JAN - 1962

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

COPY OF

CERTIFICATE OF DEATH

Cambridge

(City or Town making this return)

Registered No.

1792 216

(If death occurred in a hospital or institution, give its NAME instead of street and number)

(Was deceased a

U. S. War Veteran.

if so specify WAR.

No

St.

No

37

years

months

days

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

Married

10a If married, widowed, or divorced

HUSBAND of

Anna B. Stober

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE

64

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

Salesman

(Kind of work done during most of working life)

14 Industry

or Business:

automobile

15 Social Security No.

030-09-0120

16 BIRTHPLACE (City)

(State or country)

Walden

Mass.

17 NAME OF

FATHER

William Vance

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER

Annie Mullen

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Chelsea

21

Informant

(Address)

Mrs. Anna B. Stober Vance

89 Norman St. Winthrop

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Dec. 15,

1961

RECEIVED



JAN 19 1962 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 36, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSMEDICAL EXAMINER'S
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 217

No. 56 Crystal Cove Avenue, Winthrop

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME STEPHEN KILBURY

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a

{ U. S. War Veteran,

{ if so specify WAR)

(a) Residence. No. 56 Crystal Cove Avenue, Winthrop

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 13, 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)

Broncho pneumonia

5 Accident, suicide, or homicide (specify)

Date and hour of injury19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

Manner of

Injury

(Specify type of place)

Nature of

Injury

(How did injury occur?)

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation or deceased?

If so, specify

(Signed)

George W. Curtis, M.D.

(Print or type name)

(Address) Boston Date 12/13, 1961

7 Winthrop Cemetery, Winthrop
Place of Burial, or Cremation (City or Town)

DATE OF BURIAL Dec. 14, 1961

8 NAME OF FUNERAL DIRECTOR Ernest P. Gagliano

ADDRESS 147 Winthrop St., Winthrop

Received and filed DEC 14 1961 19.....

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male	10 COLOR White	11 CITIZEN OF U.S. YES ☐ NO ☐	12 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN
---------------	-------------------	---	--

12a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 DATE OF BIRTH OCT 12, 1961

14 AGE.....Years.....Months.....Days
If under 24 hours
.....Hours.....Minutes15 Usual Occupation:
(Kind of work done during most of working life)16 Industry
or Business

17 Social Security No.

18 BIRTHPLACE (City) Chelsea
(State or country) Mass.

19 NAME OF FATHER Bud Kilbury

20 BIRTHPLACE OF FATHER (City) N. Dakota
(State or country)

21 MAIDEN NAME OF MOTHER Margie M. Robbins

22 BIRTHPLACE OF MOTHER (City) Tacoma
(State or country) Washington23 Informant Bud Kilbury
(Address) 56 Crystal Cove Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

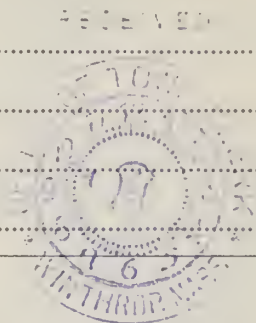
DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 219

{If death occurred in a hospital or institution,
St. { give its NAME instead of street and number}

PHYSICIAN — IMPORTANT

2 FULL NAME Thomas F. Corbett

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 15 Summit Avenue

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 15 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Dec 15, 1961, to Dec 15, 1961I last saw him alive on Dec 15, 1961, death is said to
have occurred on the date stated above, at 12:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To

(b) arteriosclerosis - gen

Due To

(c) Hypertension

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph P. Regan, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 194 Washington St. Date 12-16-1961

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 19 1961

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed DEC 18 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Julia Petzke

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years Months Days

If under 24 hours
Hours Minutes13 Usual Occupation: S. S. Clerk
(Kind of work done during most of working life)

14 Industry or Business: Steamship

15 Social Security No. 022-03-8363

16 BIRTHPLACE (City) Roxbury
(State or country) Mass

17 NAME OF FATHER Michael Corbett

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Bridget Kilcoyne

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Julia Corbett
(Address) 15 Summit Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

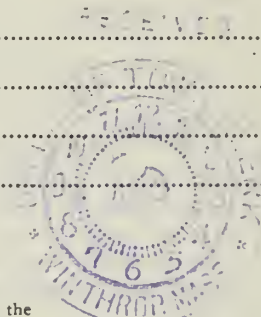
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



DEC 18 1961 AM

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop

(City or Town)

No.

7 Siren Street

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No.

250

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
(if so specify WAR)

2 FULL NAME

Charles Adams Reed

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

7 Siren Street

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 39 years months days. In place of residence 39 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHDecember 17 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw him alive on 19 death is said to
have occurred on the date stated above, at 5:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To

(b) Presumably Coronary Occlusion

Due To

(c) Arteriosclerotic Heart Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? post mortem judgement

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed)

Arthur C. Murray M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop Board of Health Date 18 Dec 1961

6 Woodlawn Crematory

Everett

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Dec. 20 1961

7 NAME OF

FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed

DEC 19 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED married10a If married, widowed, or divorced
HUSBAND of Georgia Thurston

(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 75 Years 0 Months 0 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Salesman

(Kind of work done during most of working life)

14 Industry
or Business: Meat

15 Social Security No. 01-201-6854

16 BIRTHPLACE (City) West Tremont
(State or country) Maine

17 NAME OF

FATHER Nathan Reed

18 BIRTHPLACE OF

FATHER (City)

(State or country) Maine

19 MAIDEN NAME

OF MOTHER Emma Mitchel

20 BIRTHPLACE OF

MOTHER (City)

(State or country) Maine

21

Informant

(Address) Georgia Reed
7 Siren St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

M R-301A

PLACE OF DEATH

INSTRUCTIONS
FOR
L CERTIFICATEa giving
OF DEATHnot enter
e than one
e for each
(b) and (c)does not mean
de af dying,
heart failure,
etc. It means
use, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but nat
a the terminal
condition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

6-59-925686

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

DEC 19 1961 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHot enter
than one
for each
b) and (c)es not mean
of dying,
heart failure,
tc. It means
r, or compli-
which causedns, if any,
ave rise to
ause (a),
the under-
ause last.ions contrib-
death but not
the terminal
dition givenChapter 137,
1954, requires
to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Peter Norcott

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

36 Forrest St.

(a) Residence. No.

(Usual place of abode)

St.

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death years months 7 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec 24 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Oct 3, 1961, to Dec 24, 1961I last saw him alive on Dec 23, 1961, death is said to
have occurred on the date stated above, at 6:02 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinoma

Due To
(b) adenocarcinoma StomachDue To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? no
What test confirmed diagnosis? aspiration5 Was disease or injury in any way related to occupation of deceased?
If so, specify no

(Signed) H. B. Greenfield, M. D.

(PRINT OR TYPE SIGNATURE)
4475 Winthrop Ave

(Address) Winthrop, Mass. Date 12-24 1961

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 27 1961

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS 325 Chelsea St. E. Boston

Received and filed DEC 26 1961

(Registrar)

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 251

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran, if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED
WIDOWED married
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Lorna M. Cusack
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 51 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: fisherman
(Kind of work done during most of working life)

14 Industry or Business: Lawrence Soule

15 Social Security No. 020-14-9783

16 BIRTHPLACE (City) Harbor Grace
(State or country) Newf.

17 NAME OF FATHER Michael Norcott

18 BIRTHPLACE OF FATHER (City) Newfoundland
(State or country)

19 MAIDEN NAME OF MOTHER Mary Ann Fayes

20 BIRTHPLACE OF MOTHER (City) Newfoundland
(State or country)21 Informant Lorna M. Norcott
(Address) 36 Forrest St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Milton

(City or town making return)

Registered No. 252

Norfolk

(County)

Milton

(City or Town)

No. 152 Robbins

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME John Fitzgerald

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a

{ U. S. War Veteran,
(if so specify WAR)

(a) Residence. No. 439 Winthrop

(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death 3 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 26, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)

Presumably Coronary Occlusion

Fell Dead

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19.

If accidental, was injury causally related to the death?

Where did
Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

(Specify type of place)

Manner of
Injury

(How did injury occur?)

Nature of
Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Frederic Tudor

M. D.

(Address) Milton, Mas.

Date 12-26-61

7 Holy Cross Malden, Mass.

Place of Burial, or Cremation,

(City or Town)

DATE OF BURIAL Dec. 29th, 19 61

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop, Mass.

Received and filed 19.

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

Male

10 COLOR

White

11 SINGLE (write the word)

MARRIED

WIDOWED Single

or DIVORCED

11a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE 65 Years Months Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

Longshoreman

(Kind of work done during most of working life)

15 Industry

or Business:

Docks

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

East Boston

Mass.

18 NAME OF
FATHER

Michael Fitzgerald

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Boston

Mass.

20 MAIDEN NAME

OF MOTHER

Elizabeth Daly

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

East Boston

Mass.

22

Informant

(Address)

Mrs. Ziegler

139 Winthrop St. Winthrop, Mass.

A TRUE COPY.

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

December 27th

19 61

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

DEC 28 1951

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.Suffolk
(County)Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Max Katz

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 37 Trident Ave
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....3.....days. In place of residence 45.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC 29 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JAN 1961, to DEC 29 1961I last saw him alive on 12/29 1961, death is said to
have occurred on the date stated above, at 1:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) NEPHROSCLEROSIS - UREMIA

(b) Due To ARTERIO-SCLEROTIC HEART DIS 3 YRS.

(c) Due To GENERAL ARTERIO SCLEROSIS 3 YRS.

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL + LABORATORY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify(Signed) Myron N. King M.D.
222 PLEASANT ST WINTHROP 5, MASS
(PRINT OR TYPE SIGNATURE)
(Address) MYRON N. KING M.D. Date 12/29 19616 AMERICAN AUSTRIAN NO BORN
Place of Birth or Cremation (City or Town)

DATE OF BURIAL 10 DEC 1961 1961

7 NAME OF FUNERAL DIRECTOR BENJAMIN BIENBACH

ADDRESS 1668 BEACON ST BKL.

Received and filed DEC 29 1961 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED MARRIED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of IDA HOFFMAN
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: FURNITURE DEALER
(Kind of work done during most of working life)

14 Industry or Business: RETIRED

15 Social Security No. NONE

16 BIRTHPLACE (City) AUSTRIA
(State or country)

17 NAME OF FATHER JACOB KATZ

18 BIRTHPLACE OF FATHER (City) AUSTRIA
(State or country)

19 MAIDEN NAME OF MOTHER LILLIAN

20 BIRTHPLACE OF MOTHER (City) AUSTRIA
(State or country)21 Informant JACK KATZ
(Address) 524 CLINTON RD BKLI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

1 R-301A

PLACE OF DEATH

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHot enter
than one
for each
(b) and (c)es not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which causedns, if any,
ave rise to
cause (a),
the under-
cause last.tions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
quires Physi-
print or type
der signature.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

DEC 29 1901 PM
 RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SUFFOLK

(County)

BOSTON

(City or Town)



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
of its **10504**

Registered No.

No. **Massachusetts General Hospital BAKER MEMORIAL**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Evelyn Cohen**

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) **No**

(a) Residence **370 Shirley St., Winthrop, Mass.** St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay. In place of death..... years..... months..... days. In place of residence **21** years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Nov. 5, 1961**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That we attended deceased from
Oct. 31, 1961 to **Nov. 5, 1961**

We last saw him live on **Nov. 5, 1961** death is said to

have occurred on the date stated above, at **4:10 p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Subarachnoid Hemorrhage**(b) **Rupture of Aneurysm of**(c) **Right Internal Carotid Artery**

Interval between onset and death **6 days**

OTHER SIGNIFICANT CONDITIONS **Lobar Pneumonia**

Interval between onset and death **6 days**

Was autopsy performed? **Yes**What test confirmed diagnosis? **Autopsy**

5 Was disease or injury in any way related to occupation of deceased?
If so, specify **C. L. Clay**

(Signed) **Charles L. Clay, M.D.** M. D.

(PRINT OR TYPE SIGNATURE)

(Address) **Ass't. Dir., Mass. Gen'l. Hosp. Date Nov. 5, 1961**

6 **CHEVRAH TORAH** **EVERTT**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Nov 7** 19**61**

7 NAME OF FUNERAL DIRECTOR **TORF FUNERAL SERVICE**

ADDRESS **CHESEA**

Revised and filed **NOV 8 1961**

Charles J. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)

MARRIED

10a If married, widowed, or divorced **HERMAN COLE**

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **60** Years..... Months..... Days If under 24 hours

..... Hours..... Minutes

13 Usual Occupation: **House wife**

(Kind of work done during most of working life)

14 Industry or Business: **OWN HOME**

15 Social Security No. **None**

16 BIRTHPLACE (City) **Chelsea, Mass**

(State or country)

17 NAME OF FATHER **HERSH KAUFMAN**

18 BIRTHPLACE OF FATHER (City) **RUSSIA**

(State or country)

19 MAIDEN NAME OF MOTHER **ANN - (C.B.L.)**

20 BIRTHPLACE OF MOTHER (City) **RUSSIA**

(State or country)

21 Informant **Herbert W. Cole**

(Address) **23 Noble St West Newton**

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued:

J. H. H. H. (Signature of Agent of Board of Health or other)

4368 (Official Designation)

11/6/61 (Date of Issue of Permit)

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

In giving
USE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

which does not mean
mode of dying,
as heart failure,
emphysema, etc. It means
disease, or compli-
cations which caused
death.

Conditions contrib-
uting to death but not
causing the terminal
condition given
(a).

333
M.C.

Note: Chapter 137,
Acts of 1954, requires
physicians to print or
type the cause or
causes of death on
death certificates, and
Chapter 48, Acts of
1959, requires Physi-
cians to print or type
name under signature

al Directors

ase use only

LACK Ink.

JAN 30 1962

A TRUE COPY ATTEST:

Charles H. Mackie

County Registrar



JAN 3 01362 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

10583

PLACE OF DEATH

SU1FFOK

(County) BOSTON

BETH ISRAEL

(City or Town)

HOSPITAL

STANDARD CERTIFICATE OF DEATH

No. BOSTON.

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

Registered No.

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) no

2 FULL NAME SAMUEL KAPLOW

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 18 TRIDENT AVE.

St. WINTHROP, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 14 days. In place of residence, years, months, days.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

In giving
SE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
kid, etc. It means
disease, or compli-
as which caused

ditions, if any,
ich gave rise to
ve cause (a),
ting the under-
ng cause lost.

ditions contrib-
to death but not
to the terminal
e condition given
).

(Ca-Cancer of Colon)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 10/23/61 November 8, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10/23/61 to 11/8/61

1 last saw him alive on 11/8/61, death is said to have occurred on the date stated above, at 4 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) SEPTICEMIA II

Due To (b) ca of colon with left colectomy

Due To (c) Wound infection

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? Operation

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) [Signature] M. D.

(PRINT OR TYPE SIGNATURE)

(Address) BETH ISRAEL Date 11/8/61

6 Jewish Deed Holders, Everett.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 9, 1961

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline.

Received and filed NOV 9 1961

Charles A. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED married

10a If married, widowed, or divorced HUSBAND of Sadie Cohen (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Grocer (retired) (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 013-28-6174

16 BIRTHPLACE (City) (State or country) Russia

17 NAME OF FATHER George Kaplow

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Sarah (unknown)

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Sadie Kaplow (Address) 18 Trident Ave., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

A20936 (Official Designation)

NOV 8, 1961 (Date of Issue of Permit)

AN 30 1962

1.B.V

A TRUE COPY ATTEST.

Charles H. Mackie

City of New York



JAN 30 1962 PM

INSTRUCTIONS
FOR
VITAL CERTIFICATE

In giving
STATE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
pneumonia, etc. It means
disease, or complica-
tion which caused

Conditions, if any,
which gave rise to
the cause (a),
including the under-
lying cause last.

Conditions contrib-
uting to death but not
leading to the terminal
condition given

Chapter 137,
Acts of 1954, requires
physicians to print or
type the cause or
causes of death on
both certificates, and
Chapter 48, Acts of
1927, requires Physi-
cians to print or type
the under signature.

Local Director

Use only

BLACK Ink.

NOV 30 1962

X

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL

2 FULL NAME Harry Mc Grath Jr.

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name)

(a) Residence, No. 34 Enfield Rd.
(Usual place of abode)

Winthrop.

Massachusetts

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 14, 1961

(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from November 10, 1961 to November 14, 1961

My last saw him live on November 14, 1961 death is said to have occurred on the date stated above, at 1:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Intracerebral Hemorrhage

(a)

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Charles L. Cley, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Asst. Dir., Mass. Gen'l. Hosp. November 14, 1961

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 17, 1961

7 NAME OF FUNERAL DIRECTOR Chas. B. Watson

ADDRESS Cambridge, Mass.

Received and filed NOV 16 1961

Charles H. Mackie (Registrar)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent

Registered No. 10792

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U.S. War Veteran,
if so specify WAR) WWI

PERSONAL AND STATISTICAL PARTICULARS

8 SEX
M

9 COLOR
White

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married

10a If married, widowed, or divorced
HUSBAND of Virginia Ingersoll
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 40 Years 11 Months 5 Days
If under 24 hours
Hours. Minutes

13 Usual Occupation: Insurance Agent
(Kind of work done during most of working life)

14 Industry or Business: Rigby-McGrath

15 Social Security No. 017-16-2576

16 BIRTHPLACE (City) Somerville, Mass.
(State or country)

17 NAME OF FATHER Harry A. McGrath Sr.

18 BIRTHPLACE OF FATHER (City) Somerville
(State or country)

19 MAIDEN NAME OF MOTHER Julia Coakley

20 BIRTHPLACE OF MOTHER Somerville, Mass.
(State or country)

21 Informant Harry A. McGrath Sr.
(Address) 16 Bangley Ridge, Winchester

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.
Edward McAllister
(Signature of Agent of Board of Health or other)

A21082 NOV 14, 1961
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles R. Mackie

CL. Secy. 1947

IAN 30 1962 AM

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agency

STANDARD
CERTIFICATE OF DEATH

Registered No. **11080**

Suffolk
(County)

Boston
(City or Town)

No. **New England Deaconess Hospital**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
PHYSICIAN -- IMPORTANT

2 FULL NAME **Mr. Robert Allen**

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
{ U. S. War Veteran, No
{ if so specify WAR)

(a) Residence No. **39 Circuit Road**
(Usual place of abode)

St. **Winthrop, Mass.**
(If nonresident, give city or town and State)

Length of stay: In place of death **12** days. In place of residence **2** years **12** months **12** days.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

In giving
USE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
mode of dying,
as heart failure,
emia, etc. It means
disease, or compli-
cations which caused
it.

Conditions, if any,
which gave rise to
the cause (a),
affecting the under-
lying cause last.

Conditions contrib-
uting to death but not
related to the terminal
disease condition giving
rise to it.

Note: Chapter 137,
acts of 1954 requires
physicians to print or
type the cause or
causes of death on
death certificates, and
Chapter 48, Acts of
1959, requires Physi-
cians to print or type
time under signature

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **November 21 1961**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
November 9 1961 to **November 21 1961**
I last saw him alive on **November 20 1961**, death is said to

have occurred on the date stated above, at **12:45 A.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **MYOCARDIAL INFARCTION**

Due To
(b) **ARTERIOSCLEROTIC HEART DISEASE**

Due To
(c)

OTHER SIGNIFICANT CONDITIONS **DIABETES MELLITUS**

Was autopsy performed? **Yes**

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify

(Signed) **J. O. PARTAMIAN**, M. D.

(Print or Type Name)

(Address) **N.E. Deaconess Hospital 11/21/1961**

6 **Memorial Park St. Petersburg, Fla.**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Nov. 25 1961**

7 NAME OF FUNERAL DIRECTOR **Howard S. Reynolds**

Winthrop, Mass

ADDRESS

Received and filed **NOV 27 1961**

Charles E. Mackie

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 CITIZEN OF U.S. **YES** ☐ NO ☐ 11 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of **Margaret Kilen**
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 DATE OF BIRTH

13 AGE **79** Years **7** Months **3** Days If under 24 hours
Hours Minutes

14 Usual Occupation: **Meat Dealer**
(Kind of work done during most of working life)

15 Industry or Business: **Market**

16 Social Security No. **022-05-2565**

17 BIRTHPLACE (City) **Boness**
(State or country) **Scotland**

18 NAME OF FATHER **James Allen**

19 BIRTHPLACE OF FATHER (City) **Scotland**
(State or country)

20 MAIDEN NAME OF MOTHER **Elizabeth Hamilton**

21 BIRTHPLACE OF MOTHER (City) **Scotland**
(State or country)

22 Informant **E Jean Chambers**
(Address) **39 Circuit Rd. Winthrop, Mass.**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

R. H. Rogerson
(Signature of Agent of Board of Health or other)

A4612 11/22/61
(Official Designation) (Date of Issue of Permit)

AN 30 1962

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

IAN 3 11 1962 AM

11227

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Registered No.

No. Massachusetts General Hospital BAKER MEMORIAL

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME: SARAH L. Nolan

(McDERMOTT)

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

11 Emerson Rd., Winthrop, Mass.

(a) Residence No. St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, years months 2 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 22, 1961

(Month) (Day) (Year)

4 Nov. 22, 1961 to Nov. 22, 1961 The deceased from

last saw him alive on Nov. 22, 1961, death is said to

have occurred on the date stated above, at m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Pancreatitis

(b) Acute Cholecystitis

(c) Cholelithiasis

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes Autopsy

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles L. Cleary, M.D. M. D.

(PRINT OR TYPE SIGNATURE) Nov. 22, 1961

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date: 19.....

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 27 1961

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY

ADDRESS WINTHROP

Received and filed Charles J. Mack NOV 28 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED
WIDOWED WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of JOSEPH D. NOLAN
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: SALES CLERK
(Kind of work done during most of working life)

14 Industry or Business: DEPARTMENT STORE

15 Social Security No. 016-18-3242

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

17 NAME OF FATHER WILLIAM T McDERMOTT

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) MASS

19 MAIDEN NAME OF MOTHER DORA SHEEHAN

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) MASS

21 Informant MRS. MARIE WOLF
(Address) 11 EMERSON RD WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

K. R. Rogers
(Signature of Agent of Board of Health or other)

4631
(Official Designation)

11/24/61
(Date of Issue of Permit)

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

In giving
STATE OF DEATH

do not enter
more than one
cause for each
a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
etc. It means
disease, or compli-
cations which caused

conditions, if any,
which gave rise to
the cause (a),
being the under-
lying cause last.

conditions contrib-
ute to death but not
lead to the terminal
condition given

ote - Chapter 137,
of 1954, requires
physicians to print or
type the cause or
causes of death on
all certificates, and
Chapter 48, Acts of
1954, requires Physi-
cians to print or type
their signature

al Directors
use only
BLACK Ink.

NOV 30 1962

A TRUE COPY ATTEST:

Charles R. Mackie

Gen. Sec. War

IAN 30 1952 '4

PLACE OF DEATH

Suffolk
(County)
Roslindale
(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its agent
11226
Registered No.

STANDARD
CERTIFICATE OF DEATH

No. Recuperative Centre, 1245 Centre St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME THOMAS J. SHEA
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) YES 1

(a) Residence. No. 190 Somerset Avenue St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

In giving
SE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

his does not mean
mode of dying,
as heart failure,
pneumonia, etc. It means
disease, or complica-
tion, which caused

ditions, if any,
which gave rise to
the cause (a),
including the under-
lying cause last.

conditions contrib-
uting to death but not
responsible for the terminal
condition given
(b).

Chapter 14C,
of 1954, requires
physicians to print or
write the cause or
causes of death on
all death certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 22 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
NOV 1 1961 to NOV 21 1961

I last saw him alive on NOV 21 1961, death is said to
have occurred on the date stated above, at 5 55 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC - MYOCARDIAL INFARCTION

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To CORONARY ARTERIOSCLEROSIS
(b) YEARS

Due To
(c)

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 4 YEARS

Was autopsy performed? NO

What test confirmed diagnosis? ELECTROCARDIOGRAMS

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) John P. Sullivan, M. D.

(Address) 442 Beacon St Boston Date 11-22 1961

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 27th 1961

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed NOV 28 1961 19

Charles H. Inactive (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Telephone Pioneer
(Kind of work done during most of working life)

14 Industry or Business: N.E. Telephone

15 Social Security No. 011-07-2592

16 BIRTHPLACE (City) East Boston

(State or country) Mass.

17 NAME OF FATHER Patrick Shea

18 BIRTHPLACE OF FATHER (City) Ireland

(State or country)

19 MAIDEN NAME OF MOTHER Mary O'Brien

20 BIRTHPLACE OF MOTHER (City) Ireland

(State or country)

21 Informant Mrs. Mildred Shea

(Address) 190 Somerset Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me HERE (If the burial or transit permit was issued,

(Signature of Agent of Board of Health or)

4636 (Official Designation)

11/24/61 (Date of Issue of Permit)

SOM-9-56-917973

N 30 1962

A TRUE COPY ATTEST:

Charles P. Mackie

City Registrar

IAN 3 01362 AM

PLACE OF DEATH

SUPPOLK

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent

STANDARD
CERTIFICATE OF DEATH

Registered No.

11705

2 FULL NAME Ellen Mitchell (Hyland)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
[(If death occurred in a hospital or institution, give its NAME instead of street and number)]
PHYSICIAN - IMPORTANT
[(Was deceased a U. S. War Veteran, if so specify WAR)]

11 Moore Street Winthrop, Massachusetts

(a) Residence, No. (Usual place of abode) (If non-resident, give city or town and State)

Length of stay: In place of death... years... months... 2 days. In place of residence... years... months... 60 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 5 1961
(Month) (Day) (Year)

4 DECEASED CERTIFIED That attended deceased from December 3 1961, to December 5 1961.

Last saw her alive on December 5 1961, death is said to have occurred on the date stated above, at 5:40p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

(b)

(c)

(d)

(e)

(f)

(g)

(h)

(i)

(j)

(k)

(l)

(m)

(n)

(o)

(p)

(q)

(r)

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A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



FEB 14 1962 AM

SUFFOLK

(County)

BOSTON

(City or Town)

No. New England Center Hospital

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent

11873

Registered No.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

2 FULL NAME Stamatios

(First Name)

(Middle Name)

Booras

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 82 Locust St
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months 3..... days. In place of residence 40..... years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 10, 1961

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
December 7, 1961 to December 10, 1961

I last saw him alive on December 10, 1961, death is said to
have occurred on the date stated above, at 6.00a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHOPNEUMONIA

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS

APLASTIC ANEMIAWas autopsy performed? YESWhat test confirmed diagnosis? YES

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signed) F. M. Appleton, M. D.F. M. APPLETON

(PRINT OR TYPE SIGNATURE)

(Address) NEC HOSPITAL Date 12/10 1961BOSTON, MASS.

Winthrop Cem Winthrop, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DECEMBER 13 19617 NAME OF FUNERAL DIRECTOR Charles J. HackettADDRESS 1642 Commonwealth Ave. BostonReceived and filed DEC 14 1961 1961Charles J. Hackett

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MALEWHITEMARRIED

10a If married, widowed or divorced,
HUSBAND of ANNA PAPPADOPOULOS

(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 76 Years..... Months..... Days

If under 24 hours

Hours..... Minutes

Occupation: IMPORTER
(Kind of work done during most of working life)

14 Industry or Business:

OLIVE OIL15 Social Security No. 012-01-4972

16 BIRTHPLACE (City) (State or country)

GREECE

17 NAME OF FATHER

PARASKEVAS BOORAS

18 BIRTHPLACE OF FATHER (City) (State or country)

GREECE

19 MAIDEN NAME OF MOTHER

MARINA KAMARENOS

20 BIRTHPLACE OF MOTHER (City) (State or country)

GREECE

21

Informant (Address)

ANNA BOORAS
82 LOCUST ST. WINTHROP, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
(b) and (c)

is not mean
of dying,
heart failure,
etc. It means
the under-
cause last.

ions con-
death but for
the terminal
condition given

Chapter 137,
1954, requires
to print or
cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

B 14 1962

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



FEB 14 1962 AM

RM R-301

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health

or 12191

Registered No.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Mae Hale (Corson)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran.
{if so specify WAR) no

(a) Residence, No. 10 Perkins Street Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death..... years..... months..... days. In place of residence..... years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 20 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Dec 19 61, to December 20 61, 1961

deceased saw him alive on December 20, 1961, death is said to
have occurred on the date stated above, at 6:55p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Infarction

INTERVAL
BETWEEN
ONSET AND
DEATH
1 d.

Due to Chronic Heart Disease 10 yrs.

Due To (c) Pulmonary Edema 1 d.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Asst. Dir. Mass. Gen. Hosp. Date Dec. 20 1961

Place of Burial or Cremation Pine Hill Cemetery, Dor., N.H.
(City or Town)

DATE OF BURIAL Dec. 23, 1961

7 NAME OF FUNERAL DIRECTOR Ernest P. Cassiano

ADDRESS 147 1/2 St. Winthrop

Received and filed DEC 26 1961

5091 12/21/61
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Percy Hale (Husband's name in full)

12 DATE OF BIRTH Oct. 23, 1906

13 AGE 55 Years 1 Months 22 Days If under 24 hours
Hours Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: at home

16 Social Security No.

17 BIRTHPLACE (City) Exeter
(State or country) N. H.

18 NAME OF FATHER C. L. Corson

19 BIRTHPLACE OF FATHER (City) N. H.
(State or country)

20 MAIDEN NAME OF MOTHER Ida Mae Littlefield

21 BIRTHPLACE OF MOTHER (City) Maine
(State or country)

22 Informant Percy Hale
(Address) 10 Perkins St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

INSTRUCTIONS
FOR
CERTIFICATE

in giving
OF DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

itions if any,
var time to
cause (as,
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

e. Chapter 137,
ol 1954 requires
cians to print or
the cause or
s of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

Director

to use only

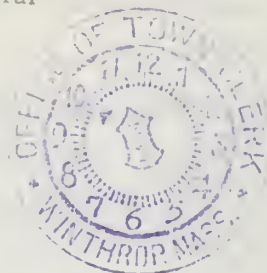
ACK Ink.

DEC 14 1962

61-3393

A TRUE COPY ATTEST:

Charles H. Mackie
City Registrar



FEB 14 1962 AM

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. NEW ENGLAND


 JOSEPH D. WARD
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

 STANDARD
 CERTIFICATE OF DEATH
 HOSPITAL

 To be filed for burial permit
 with Board of Health
 or its Agent.

Registered No.

12398

2 FULL NAME

WILLIAM

JOSEPH

MYTHEN

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No.

(Usual place of abode)

89 COTTAGE

89 COTTAGE AVE.

Winthrop

 (If death occurred in a hospital or institution,
 St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR)

no

(If nonresident, give city or town and State)

Length of stay: In place of death years months 30 days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH DECEMBER 25 1961
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
 11-26-1961, to 12-25-1961

 I last saw him alive on 12-24-1961, death is said to
 have occurred on the date stated above, at 7:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

 True To RESECTION CANCER SIGMOID
 (b) COLON

 Due To
 (c)

OTHER SIGNIFICANT CONDITIONS

CARCINOMA CECUM

Was autopsy performed?

NO

What test confirmed diagnosis?

 5 Was disease or injury in any way related to occupation of deceased? NO
 If so, specify

(Signed)

I. T. KHUCHENAWI, M. D.

(Address)

New ENGLAND HOSPITAL Date 12/25/1961

6 Holy Cross

Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Dec. 28 1961

7 NAME OF FUNERAL DIRECTOR

Frederick J. McGrath

ADDRESS

East Boston

Received and filed

DEC 28 1961

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED
 10a If married, widowed, or divorced, HUSBAND of Edward J. Cassidy
 (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 77

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

class business

(Kind of work done during most of working life)

14 Industry

or Business:

proprietor

15 Social Security No.

027-28-4595

 16 BIRTHPLACE (City) Somerville, Mass.
 (State or country)

17 NAME OF FATHER

Cath Mythen

18 BIRTHPLACE OF

FATHER (City)

(State or country)

England

19 MAIDEN NAME

OF MOTHER

Catherine Hoye

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21

Informant

(Address)

Phyllis Mythen

89 Cottage Ave. Winthrop

 I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

14 1962

A TRUE COPY ATTEST:

Charles H. Mackin

City Registrar

RECEIVED



FEB 14 1962 AM

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 12626

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles Smith
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 165 Woodside Avenue St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 6 days. In place of residence, 55 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 31, 1961
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
December 25, 1961, to December 31, 1961

5 I last saw him live on December 31, 1961, death is said to
have occurred on the date stated above, at 2:20p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary edema

Due To Arteriosclerotic
(b) heart disease.

Due To Aortic stenosis
(c)

OTHER
SIGNIFICANT
CONDITIONS no.

Was autopsy performed? no.
What test confirmed diagnosis? clinical.

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles L. Clay, M.D.
(Print or Type Name)
(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Dec. 31, 1961

6 Burial Place of Burial or Cremation Reabody
(City or Town)

DATE OF BURIAL Jan. 3, 1962

7 NAME OF DIRECTOR FUNERAL Howard S. Reynolds
Winthrop, Mass.

ADDRESS

Received and filed JAN 4 1962
Charles H. Mackie (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 CITIZEN OF U.S. YES ☐ NO ☐ 11 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of Ethel Adams
(Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH AGE 35 Years, 5 Months, 26 Days If under 24 hours Hours Minutes

13 Usual Occupation: Engineer
(Kind of work done during most of working life)

14 Industry or Business: Railroad

16 Social Security No. 022-10-3792

17 BIRTHPLACE (City) Biddeford
(State or country) Maine

18 NAME OF FATHER Andrew Smith

19 BIRTHPLACE OF FATHER (City) Biddeford
(State or country) Maine

20 MAIDEN NAME OF MOTHER Valire Lewis

21 BIRTHPLACE OF MOTHER (City) Biddeford
(State or country) Maine

22 Informant Ethel Smith
(Address) 155 Woodside Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

5291 1-2-62
(Official Designation) (Date of Issue of Permit)

INSTRUCTIONS
FOR
L CERTIFICATE

giving
OF DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ion, if any,
rise to
se (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Chapter 137,
of 1954 requires
to print or
the cause or
of death on
certificates, and
er 48. Acts of
requires Phys-
to print or type
under signature.

Director
use only
CK Ink.

14 1962
61-930213

V.B.V.

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



FEB 14 1962 AM

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

265

Suffolk

(County)

Chelsea

(City or Town)

Chelsea

(City or town making return)

Registered No. 447

PLACE OF DEATH

No. U.S. Naval Hosp.

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME Annie Almira Marden (Delano)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 91 Winthrop
(Usual place of abode)St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death years months 1 days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 8 1961
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)Myocardial Infarction due to
Arteriosclerotic Heart Disease

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

Where did
Injury occur? (City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public
place? (Specify type of place)Manner of
Injury (How did injury occur?)Nature of
Injury

While at work? Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased?

If so, specify no

(Signed) Lockhart B. McGuire M. D.

(Address) U.S. Naval Hosp., Chelsea, 9/9/61

7 Winthrop Cem., Winthrop, Mass.

Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL 11 September 1961

8 NAME OF FUNERAL DIRECTOR Reynolds Funeral Home

ADDRESS 180 Winthrop St., Winthrop, Mass.

Received and filed MAR 15 1962

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR OR RACE 11 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married
Female White11a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Harry S. Marden
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 72 Years 1 Months 27 Days If under 24 hours
Hours Minutes14 Usual Occupation: Housewife
(Kind of work done during most of working life)15 Industry Own home
or Business:

16 Social Security No. 029-22-2905

17 BIRTHPLACE (City) Fairfield
(State or country) Maine

18 NAME OF FATHER Milford Delano

19 BIRTHPLACE OF FATHER (City) Maine
(State or country)

20 MAIDEN NAME OF MOTHER Lillian Reynolds

21 BIRTHPLACE OF MOTHER (City) Maine
(State or country)22 Informant Harry S. Marden
(Address) 91 Winthrop St., Winthrop, Mass.

A TRUE COPY.

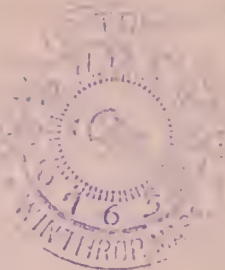
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 9/11 1961

M R-305

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-303 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-5-52-907046



MAR 15 1962 AM

