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FORM R-301

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

INSTRUCTIONS
FOR
EDICAL CERTIFICATE

PRINT OR TYPE
USE OR CAUSES
OF DEATH

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

This does not mean
mode of dying,
h as heart failure,
hemia, etc. It means
disease, or complica-
tions which caused
it.

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

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

M.C.

P. 12.1

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 1

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 831 Shirley St

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

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

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, WW 2
if so specify WAR)}

(a) Residence No. 831 Shirley St. Winthrop, MASS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years 0 months 0 days. In place of residence 50 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 2, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Oct 11, 1964, to Dec 31, 1964
I last saw him live on Dec 31, 1964. Death is said to
have occurred on the date stated above, at 8:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

Due To (b) arteriosclerotic heart disease 2 yrs

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Congestive heart
failure

Was autopsy performed? No

What test confirmed diagnosis? ecg

5 Was disease or injury in any way related to occupation of deceased? Yes - attack at work
If so, specify

(Signature) H. B. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Shirley St. Date 1-2 1965

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

DATE OF BURIAL January 5, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed John A. Clarke 19

(Registrar)

A TRUE COPY-ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Agnes Cronin
(Give maiden name of wife in full)

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

12 AGE 58 Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business: Real Estate

15 Social Security No. 16 BIRTHPLACE (City) Manchester Mass
(State or country)

17 NAME OF FATHER Edward H. Haley

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

19 MAIDEN NAME OF MOTHER Catherine Coyne

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

21 Informant Agnes Haley
(Address) 831 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:

Health Officer - Jan 4 1965
(Official Designation) (Date of Issue of Permit)

JAN - 5 1965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....10-13-42

DATE OF DISCHARGE.....11-26-45

RANK, RATING.....Lieutenant

ORGANIZATION AND OUTFIT.....U.S.N.R.

SERVICE NUMBER.....208868

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.

JAN - 5 1965 AM

RM R-301A

INSTRUCTIONS
FOR
CAL CERTIFICATE

In giving
SE OF DEATH
to not enter
ore than one
use for each
a), (b) and (c)

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

ditions, if any,
ch gave rise to
ve cause (a),
ing the under-
ig cause last.

onditions contrib-
to death but not
d to the terminal
se condition given
).

te:- Chapter 137,
of 1954, requires
sicians to print or
the cause or
es of death on
h certificates.

115
1000

AN - 5 1965

1000 11-55-916145

1

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

2

FULL NAME

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

(a)

Residence. No.

49 Waldemar Ave.,
(Usual place of abode)

Length of stay:

In place of death.....years.....months.....days.

In place of residence.....years.....months.....days.

3

DATE OF DEATH

JAN 2 1965
(Month) (Day) (Year)

4

I HEREBY CERTIFY, That I attended deceased from

Nov. 1962 to Jan. 2 1965

I last saw him alive on Jan 2, 1965, death is said to have occurred on the date stated above, at 6:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cirrhosis of liver

Due To (h)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Hypertension,

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 Libesman, M. D.

(Address)

Winthrop, Mass.

Date

Jan. 2 1965

6

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

DATE OF BURIAL

Jan. 5, 1965

7

NAME OF FUNERAL DIRECTOR

Howard S Reynolds

ADDRESS

Winthrop, Mass.

Received and filed

19.....

(Registrar)

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

87 Years 4 Months 6 Days

If under 24 hours

.....Hours.....Minutes

13

Usual Occupation

Maintenance
(Kind of work done during most of working life)

14

Industry or Business

Ford Motor Co.

15

Social Security No.

025-09-5780

16

BIRTHPLACE (City)

East Boston

(State or country)

Mass.

17

NAME OF FATHER

Charles Wilson

18

BIRTHPLACE OF FATHER (City)

(State or country)

Norway

19

MAIDEN NAME OF MOTHER

Emma Anderson

20

BIRTHPLACE OF MOTHER (City)

(State or country)

Sweden

21

Informant

Madaline Birkmaier

(Address)

49 Waldemar 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. Johann (Signature of Agent of Board of Health or other)

Health Officer (Official Designation)

Jan 5 1965 (Date of Issue of Permit)

1

PLATE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

2

FULL NAME

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

(a)

Residence. No.

49 Waldemar Ave.,
(Usual place of abode)

Length of stay:

In place of death.....years.....months.....days.

In place of residence.....years.....months.....days.

3

DATE OF DEATH

JAN 2 1965
(Month) (Day) (Year)

4

I HEREBY CERTIFY, That I attended deceased from

Nov. 1962 to Jan. 2 1965

I last saw him alive on Jan 2, 1965, death is said to have occurred on the date stated above, at 6:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cirrhosis of liver

Due To (h)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Hypertension,

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 Libesman, M. D.

(Address)

Winthrop, Mass.

Date

Jan. 2 1965

6

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

DATE OF BURIAL

Jan. 5, 1965

7

NAME OF FUNERAL DIRECTOR

Howard S Reynolds

ADDRESS

Winthrop, Mass.

Received and filed

19.....

(Registrar)

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

87 Years 4 Months 6 Days

If under 24 hours

.....Hours.....Minutes

13

Usual Occupation

Maintenance
(Kind of work done during most of working life)

14

Industry or Business

Ford Motor Co.

15

Social Security No.

025-09-5780

16

BIRTHPLACE (City)

East Boston

(State or country)

Mass.

17

NAME OF FATHER

Charles Wilson

18

BIRTHPLACE OF FATHER (City)

(State or country)

Norway

19

MAIDEN NAME OF MOTHER

Emma Anderson

20

BIRTHPLACE OF MOTHER (City)

(State or country)

Sweden

21

Informant

Madaline Birkmaier

(Address)

49 Waldemar 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. Johann (Signature of Agent of Board of Health or other)

Health Officer (Official Designation)

Jan 5 1965 (Date of Issue of Permit)

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Registered No. 2

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



Cliff House Nursing Home

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

Carl G Wilson

PHYSICIAN - IMPORTANT

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

49 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.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH JAN 2 1965
(Month) (Day) (Year)

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

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1962 to Jan. 2 1965
I last saw him alive on Jan 2, 1965, death is said to have occurred on the date stated above, at 6:45 P.m.

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

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

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH

(a) Cirrhosis of liver

6 mos.

Due To (h)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Hypertension,

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) Charles Libesman, M. D.
(Address) Winthrop, Mass. Date Jan. 2 1965

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

DATE OF BURIAL Jan. 5, 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass.

Received and filed 19.....

(Registrar)

PARENTS

21

Informant Madaline Birkmaier
(Address) 49 Waldemar 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. Johann (Signature of Agent of Board of Health or other)
Health Officer (Official Designation)
Jan 5 1965 (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 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 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.....

JAN-51065 12

The Commonwealth of Massachusetts

FORM R-301

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk
(County)Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 3

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 Nathan Zeidel
(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) Permanent Residence. No. ~~XXXXXX~~ 50 Cutler St.,
(Usual place of abode)

4 1/2 hrs

Winthrop, Mass.

(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 JAN 3 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased, from
Feb 1964, to 1/3 1965I last saw him alive on 1/3 1965, death is said to
have occurred on the date stated above, at 5:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE POSTERIOR MYOCARDIAL INFARCTION 4 1/2 HRS

Due To (b) GENERAL ARTERIOSCLEROSIS

Due To (c) AND ARTERIOSCLEROTIC HEART DIS 1 YR.

OTHER
SIGNIFICANT
CONDITIONS NONEINTERVAL
BETWEEN
ONSET AND
DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN11 If married, widowed, or divorced
HUSBAND of GERTRUDE POSNER
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 77 Years. — Months. — Days If under 24 hours
Hours. Minutes13 Usual Occupation Leather Stitcher Retired
(Kind of work done during most of working life)

14 Industry or Business Leather Bags

15 Social Security No. 010-24-0515

16 BIRTHPLACE (City) Minsk
(State or country) Russia

17 NAME OF FATHER Moishe Zeidel

18 BIRTHPLACE OF FATHER (City) Minsk
(State or country) Russia

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City) Minsk
(State or country) Russia

21 Informant GERTRUDE POSNER

(Address) 50 Cutler 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)

Received and filed 19.

(Registrar)

A TRUE COPY ATTEST:

MEDICAL EXAMINER DECLINED JURISDICTION

MEDICAL EXAMINER DECLINED JURISDICTION

MEDICAL EXAMINER DECLINED JURISDICTION

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MEDICAL EXAMINER DECLINED JURISDICTION

led for burial permit
Board of Health
or its Agent.INSTRUCTIONS
FOR
CAL CERTIFICATENT OR TYPE
E OR CAUSES
OF DEATHdo not enter
more than one
use for each
a), (b) and (c)does not mean
mode of dying,
as heart failure,
ia, etc. It means
sease, or compli-
which causedditions, if any,
h gave rise to
e cause (a),
ing the under-
g cause last.onditions contrib-
to death but not
to the terminal
condition given

I.C.

leil

N - 5 1965

-63-936348

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.

JAN - 51035 14

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Wayland
 (City or Town making this return)

COPY OF
 CERTIFICATE OF DEATH

Registered No. 4

PLACE OF DEATH
 1

Middlesex
 (County)
 Wayland
 (City or Town)



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

2 FULL NAME Herbert Dwight Hall
 (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) Permanent Residence. No. 274 Pleasant St. Winthrop
 (Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 8 months 3 days. In place of residence 65 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 6, 1965
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 3, 1963, to January 6, 1965.
 I last saw him live on Jan. 5, 1965 death is said to have occurred on the date stated above, at 6:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia 1 month

Due To
 (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?
 If so, specify No

(Signature) Louis N. Rashin, M. D.

(Address) Wayland, Mass. Date Jan 6, 1965

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

DATE OF BURIAL January 9, 1965

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed JAN 12 1965

(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 DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Label Bigelow
 (Give maiden name of wife in full)

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

12 AGE 91 Years 2 Months 3 Days If under 24 hours Hours Minutes

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

14 Industry or Business: Insurance Co.

15 Social Security No. 024-03-9982

16 BIRTHPLACE (City) Worcester, Mass.
 (State or country)

17 NAME OF FATHER Henry E. Hall

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

19 MAIDEN NAME OF MOTHER Hattie F. Gordon

20 BIRTHPLACE OF MOTHER (City) Dover
 (State or country) New Hampshire

21 Informant Louis Cloutier
 (Address) Burlington, Mass.

A TRUE COPY

ATTEST: Heila Sears Town Clerk
 (Registrar of City or Town where death occurred)

DATE FILED January 11, 1965

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -
 MARGIN RESERVED FOR BINDING
 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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No.

45

No. Bay View Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Nellie Chamberlin Crocker

(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. 10 Seaview Avenue

St.

(Usual place of abode)

(City or town and State)

Length of stay: In place of death. 2 years. 3 months. days. In place of residence. 45 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 7 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from FEB 1958 to JAN 7 1965

I last saw him alive on JAN 7 1965, death is said to have occurred on the date stated above, at 11:25 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCIDENT 3 DAYS

Due To (b) ARTERIO SCLEROTIC HEART DISEASE 7 YRS

Due To (c) + GENERAL ARTERIO SCLEROSIS

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 4 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

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

MYRON N. KING
(Print or Type Name)

(Address) 222 BLENHEIM ST. Date. 1/7 1965

6 Hope Cemetery Worcester, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 8, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed JAN - 8 - 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Frederick I. Crocker (Husband's name in full)

12 AGE 85 Years 6 Months 9 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. 010-07-4403

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

17 NAME OF FATHER Clarence Eustace Chamberlin

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

19 MAIDEN NAME OF MOTHER Anna Sophia Greene

20 BIRTHPLACE OF MOTHER (City) Monson (State or country) Massachusetts

21 Informant Mrs. Joseph S. Berry

(Address) 10 Seaview 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)

Ralph E. Sirimanni (M.D.)
(Official Designation) (Date of Issue of Permit)

Health officer

Jan 7/1965

A TRUE COPY ATTEST:

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

JAN - 8 1965 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.

M R-303

ed for burial permit
Board of Health
r its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

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.

100M-9-63-936348

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

(City or Town making this return)

Registered No. 6

No. 4 Charles St., Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ROBERT PAUL MURRAY
(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) Permanent Residence. No. 4 Charles St., Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years 2 months 14 days. In place of residence.....months 14 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 7, 1965
(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 interstitial pneumonia with pulmonary edema.

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?
(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,
(Signed) Michael A. Luongo, M.D.
(Print or Type Name)

(Address) Boston Date 1/8 19 65
7 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 9 19 65

8 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS WINTHROP
JAN - 8 1965

Received and filed JAN - 8 1965

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX MALE 10 COLOR WHITE 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN SINGLE

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 AGE.....Years 3 Months 14 Days If under 24 hoursHoursMinutes

14 Usual Occupation: NONE (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. NONE

17 BIRTHPLACE (City) BOSTON (State or country) MASS

18 NAME OF FATHER JAMES R MURRAY

19 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

20 MAIDEN NAME OF MOTHER PATRICIA ANNE KILEY

21 BIRTHPLACE OF MOTHER (City) BOSTON (State or country) MASS

22 Informant JAMES R MURRAY (Address) 4 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:

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

Health Officer 1/8/65 (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 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)."

FORM R-301

OUT - OF - TOWN

The Commonwealth of Massachusetts

7

Suffolk

(County)

Boston

(City or Town)

No. New England Center Hospital

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this ret

STANDARD
CERTIFICATE OF DEATH

Registered No. 0046

PHYSICIAN — IMPORTANT

2 FULL NAME Mr. Lewis C. Franklin

(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 # 1

(a) Permanent Residence. No. 181 Bartlett Road St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....9.....days. In place of residence 50.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 11, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
January 2, 1965 to January 11, 1965I last saw him live on January 11, 1965, death is said to
have occurred on the date stated above, at 12:15am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PROBABLE PULMONARY EMBOLISM

Due To OR MYOCARDIAL INFARCT.

Due To SEVERE EMPHYSEMA

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NO
What test confirmed diagnosis? CHEMICAL BLOOD STUDIES5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Thomas C. Berman, M. D.

HARRIS A. BERMAN
(Print or Type Name)

(Address) 71 HARRISON AV. BOSTON Date 1/12 1965

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

DATE OF BURIAL January 14, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JAN 18 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the w
MARRIED
WIDOWED Marrie
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Josephine Johnson
(Give maiden name of wife in full)

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

12 AG 66 Years Months Days If under 24 hours
Hours Minutes13 Usual Proprietor
Occupation (Kind of work done during most of working life)14 Industry Wool Business
or Business

15 Social Security No. 013-28-6130

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

17 NAME OF FATHER Lewis W. Franklin

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

19 MAIDEN NAME OF MOTHER Belle V. Tarbox

20 BIRTHPLACE OF MOTHER (City) Farmington, Maine
(State or country)21 Informant Josephine Franklin
(Address) 181 Bartlett Road WinthropI HEREBY CERTIFY that a satisfactory standard certificate of
was filed with me BEFORE the burial or transit permit was issued
Walter L. Larrabee
(Signature of Agent of Board of Health or other)
01328 1-13-65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

To be filed for burial permit
with Board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEPRINT OR TYPE
CAUSE OR CAUSES
OF DEATHdo not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
the mode of dying,
such as heart failure,
asthenia, 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
in (a).

M.C.

Pencil

f2001
4861
+ 70

A TRUE COPY ATTEST: \

William J. Kane.
City Registrar



JAN 27 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. **8**

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

No. **BAY VIEW NURSING HOME, STURGIS** St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **ELEANOR F HOWE (CROWLEY)**
(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) Permanent Residence. No. **16 COURT RD** St. **WINTHROP**
(Usual place of abode) (City or town and State)

Length of stay: In place of death **5** years.....months.....days. In place of residence **65** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **January 16, 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **March 5, 1950**, to **Jan. 16, 1965**
I last saw **her** alive on **Jan. 14, 1965**, death is said to have occurred on the date stated above, at **6:15 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Cerebral thrombosis with

(a) **right hemiplegia** 2 wks.
(b) **Arteriosclerotic and hypertensive heart disease** 10 yrs.
(c) **Generalized arterio-sclerosis** 15 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

(Signature) **Maurice Traubenstein, Jr.** M. D.
M. Traubenstein, Jr., M.D.
(Print or Type Name)

(Address) **73 Bartlett Rd. Jan. 18, 1965**
Winthrop, Mass. 02152

6 **WINTHROP** **WINTHROP**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **JAN 19** 19**65**

7 NAME OF FUNERAL DIRECTOR **MAURICE W KIRBY**

ADDRESS **WINTHROP**

Received and filed **JAN 19 1965** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of **M. Howe**
(Give maiden name of wife in full)
(or) WIFE of **CARLTON CROWLEY**
(Husband's name in full)

12 AGE **98** Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation **HOME MAKER**
(Kind of work done during most of working life)

14 Industry or Business **HOME**

15 Social Security No. **NONE**

16 BIRTHPLACE (City) **NEW JERSEY**
(State or country)

17 NAME OF FATHER **NOT KNOWN / CROWLEY**

18 BIRTHPLACE OF FATHER (City) **NOT KNOWN**
(State or country)

19 MAIDEN NAME OF MOTHER **NOT KNOWN**

20 BIRTHPLACE OF MOTHER (City) **NOT KNOWN**
(State or country)

21 Informant **MRS NANCY EVANS**
(Address) **16 COURT RD WINTHROP**

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

Ralph G. Sweeney (3)
(Signature of Agent of Board of Health or other)
Deborah O'Leary **January 19, 1965**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
a), (b) and (c)

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

ditions, if any,
h gave rise to
e cause (a),
ng the under-
g cause last.

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

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

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 9

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

No. Cliff House Nursing Home

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)2 FULL NAME Delia A. Daw
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 362 Shirley St., St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, 14 years, 60 months, 60 days. In place of residence, 60 years, 60 months, 60 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 17, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan 15, 1965, to JAN 17, 1965
I last saw him live on Jan 17, 1965, death is said to
have occurred on the date stated above, at 5:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia, Right Lung 4 days
Viral

Due 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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 1/18/1965

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

DATE OF BURIAL January 19, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JAN 18 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Walter E. Daw
(Husband's name in full)12 AGE 89 Years, Months, Days If under 24 hours
Hours, Minutes13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No.

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

17 NAME OF FATHER Thomas Cassell

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

19 MAIDEN NAME OF MOTHER Bridget Hanrahan

20 BIRTHPLACE OF MOTHER (City) Melrose, Mass
(State or country)21 Informant Robert T. Daw
(Address)

362 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)

A TRUE COPY ATTEST:

FORM R-301

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

ed for burial permit
Board of Health
its Agent.INSTRUCTIONS
FOR
AL CERTIFICATERT OR TYPE
UE OR CAUSES
F DEATHo not enter
ore than one
ause for each
(b), (b) and (c)does not mean
ode of dying,
as heart failure,
a, etc. It means
e, or compli-
hich causeditions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.ditions contrib-
to death but not
to the terminal
condition given

M.C.

W.C.I.

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.



JAN 18 1965

ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

RT OR TYPE
E OR CAUSES
F DEATH

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re than one
ase for each
, (b) and (c)

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

ditions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.

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

SUPFOLK
(County)
WINTHROP
(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP
(City or Town making this return)

**STANDARD
CERTIFICATE OF DEATH**

Registered No. **10**

No. **WINTHROP COMMUNITY HOSPITAL** (If death occurred in a hospital or institution, give its NAME instead of street and number)
PEARL WEINSTEIN (Cohen)
2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence. No. **677 Boulevard** st. **Revere Mass.**
(Usual place of abode) (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

3 DATE OF DEATH **JAN 18 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **Jan 18 1965** to **JAN 18 1965**
I last saw her alive on **JAN 18 1965**, death is said to have occurred on the date stated above, at **6:35 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) **RHEUMATIC HEART**
Due To (b) **DISEASE with Aortic**
Due To (c) **and Mitral Stenosis.**

INTERVAL BETWEEN ONSET AND DEATH **14 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

(Signature) **Charles Liberman**, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) **WINTHROP, MASS.** Date **1/18/1965**

Beth Israel of Cambridge, Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL **January 19, 1965**

7 NAME OF FUNERAL DIRECTOR **Arnold Golov**
ADDRESS **1668 Beacon St Brookline**

Received and filed **JAN 19 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of **Edward Weinstein**
(Husband's name in full)

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. **None**

16 BIRTHPLACE (City) (State or country) **Malden Mass.**

17 NAME OF FATHER **Harry Cohen**

18 BIRTHPLACE OF FATHER (City) (State or country) **New York City N.Y.**

19 MAIDEN NAME OF MOTHER **Beatrice C B L**

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

21 Informant **Edward Weinstein**
(Address) **677 Boulevard 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. Stream
(Signature of Agent of Board of Health or other)
Health Officer
(Official Designation) **1/18/65**
(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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 11

Suffolk
(County)

Winthrop
(City or Town)

No. 914 Shirley Street

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

PHYSICIAN — IMPORTANT

2 FULL NAME George Frederick Williams
(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. 914 Shirley Street
(Usual place of abode)

St. (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 January 18 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19 50, to Jan. 18, 19 65

I last saw him alive on Jan. 12, 19 65, death is said to have occurred on the date stated above, at 2:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of esophagus 8 mos

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Cirrhosis of Liver 10 yrs.

Was autopsy performed? No
What test confirmed diagnosis Clinical, Surgical Pathological

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

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 1/19/1965

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

DATE OF BURIAL January 21, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JAN 21 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of Josephine Flora Carr
(Give maiden name of wife in full)

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

12 AGE 63 Years 0 Months 27 Days If under 24 hours Hours Minutes

13 Usual Occupation Carpenter & Builder
(Kind of work done during most of working life)

14 Industry or Business self employed

15 Social Security No. 023-14-0059

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

17 NAME OF FATHER Wiggo Christian Williams

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

19 MAIDEN NAME OF MOTHER Laura Christophersen

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

21 Informant Mrs. George T. Williams

(Address) 914 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:

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

Health Officer
(Official Designation)

1/20/65
(Date of Issue of Permit)

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.

JAN 21 1935 AM

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

IT OR TYPE
OR CAUSES
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-
cation which caused

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

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

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

2 FULL NAME

Edward Scullin

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

63 Pond Street

(a) Residence. No.

(Usual place of abode)

St.

Billerica, Mass

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

January 22 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from
July 22, 1964 to Jan 22, 1965I last saw him alive on January 13, 1965, death is said to
have occurred on the date stated above, at 9:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

Due To Arteriosclerosis

(b)

Due To

(c)

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

(Signature) John F. Collins M.D.

(Print or Type Name)

(Address) Revere, Mass. Date 22 Jan 1965

6 Fox Hill Billerica, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 26 1965

7 NAME OF
FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed JAN 25 1965 19

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 12

(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)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Divorced

11 If married, widowed, or divorced

HUSBAND of Margaret Fewer

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE

81

11

Months

22

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

Stationary Engineer

(Kind of work done during most of working life)

14 Industry

or Business

Oil Company

15 Social Security No.

16 BIRTHPLACE (City) Central Falls
(State or country) Rhode Island

17 NAME OF

FATHER

Patrick Scullin

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER

Mary Halloran

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21 Informant Mary E Buonanno

(Address) 63 Pond St. Billerica, Mass.

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

Joseph B. Sullivan (3)

(Signature of Agent of Board of Health or other)

Health Officer

January 25, 1965

(Official Designation)

(Date of Issue of Permit)

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

JAN 25 1965 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.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **13**

Suffolk

(County)

Winthrop

(City or Town)

No. **Bay View Nursing Home**

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

PHYSICIAN — IMPORTANT

2 FULL NAME **Edna L (Higgins) Robinson**

(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. **61 Park Drive**
(Usual place of abode)

St. **Boston, Mass.**

(City or town and State)

Length of stay: In place of death **3** years **3** months **70** days. In place of residence **70** years **3** months **70** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **January 23, 1965**

(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
May 1, 1964, to Jan. 23, 1965.

I last saw her live on **Jan. 23, 1965.** death is said to
have occurred on the date stated above, at **11:40 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Acute myocardial infarction**

Due To (b) **Arteriosclerotic heart disease**

Due To (c) **Viral infection, respiratory**

INTERVAL
BETWEEN
ONSET AND
DEATH

15 min

4 yrs.

3 days

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

(Signature) **Maurice Traunstein Jr.**, M. D.

Maurice Traunstein, Jr., M.D.

(Print or Type Name)

(Address) **73 Bartlett Rd.** Date **Jan 25, 1965**

6 **Oak Grove** **Medford, Mass.**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Jan. 26**, 19 **65**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop Mass.**

Received and filed **JAN 25 1965**, 19 **65**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **Robert O Robinson**

(Husband's name in full)

12 AGE **74** Years **6** Months **3** 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: **Water Proofing Co**

15 Social Security No. **Somerville Somerville,**

16 BIRTHPLACE (City), (State or country) **Mass.**

17 NAME OF FATHER **Frederick W Higgins**

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

19 MAIDEN NAME OF MOTHER **Ola A Brown**

20 BIRTHPLACE OF MOTHER (City), (State or country) **Andover New Hampshire**

21 Informant **Dorothy Higgins**

(Address) **146 Cottage Pl. 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:

Ralph E. Lorcann (B)

(Signature of Agent of Board of Health or other)

Health Officer
(Official Designation)

January 25, 1965
(Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

nd for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
pre than one
use for each
(a), (b) and (c)

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

ditions, if any,
h gave rise to
e cause (a),
ing the under-
r cause last.

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

JAN 25 1965 PM

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

JAN 25 1965 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.

RECEIVED



JAN 25 1965 PM

ed for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

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

h does not mean
ode of dying,
s heart failure,
es, etc. It means
ease, or compli-
on which caused

ditions, if any,
h gave rise to
er cause (a),
ing the under-
i cause last.

ditions contrib-
go death but not
e to the terminal
a condition given

Revere 2-3-65
Suffolk
(County)
Winthrop
(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **14**

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

2 FULL NAME **Mary A. Stanchi (Sicuriello)** (If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence, No. **163 Rumney Rd.** St. **Revere, Mass.** (City or town and State)

Length of stay: In place of death, **21** years, **10** months, **10** days. In place of residence, **10** years, **10** months, **10** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **JANUARY 25 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **JANUARY 4 65**, 19**65**, to **JANUARY 25 65**, 19**65**.

I last saw him alive on **JANUARY 24 1965**, death is said to have occurred on the date stated above, at **5:25 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) **INOPERABLE CARCINOMA OF STOMACH -**
(b) _____
(c) _____

INTERVAL BETWEEN ONSET AND DEATH
MOS.

OTHER SIGNIFICANT CONDITIONS
DIABETE MELLITUS.
MOS

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of _____ (Give maiden name of wife in full)
(or) WIFE of **ROBERT R. STANCHI** (Husband's name in full)

12 AGE **56** Years **6** Months **1** 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) **EAST BOSTON** (State or country) **MASS.**

PARENTS

17 NAME OF FATHER **ANGELO SICURIELLO**

18 BIRTHPLACE OF FATHER (City) _____ (State or country) **ITALY**

19 MAIDEN NAME OF MOTHER **IDA UNKNOWN**

20 BIRTHPLACE OF MOTHER (City) _____ (State or country) **ITALY**

Was autopsy performed? **NO**
What test confirmed diagnosis? **SURGERY.**

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

(Signature) **D. Thomas Staffier** M. D.
D. Thomas STAFFIER
(Print or Type Name)
(Address) **21 BREED STREET** Date **JANUARY 25 1965**

6 **HOLY CROSS CEMETERY, MALDEN, MASS.**
Place of Burial or Cremation (City or Town)
DATE OF BURIAL **JANUARY 28, 1965**

7 NAME OF FUNERAL DIRECTOR **LAWRENCE BRUNO**
ADDRESS **291 REVERE STREET, REVERE, MASS.**
JAN 27 1965

Received and filed _____ 19____

(Registrar)

21 Informant **ROBERT R. STANCHI (HUSBAND)**
163 RUMNEY RD. REVERE, MASS.
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Siricani, M.D.
(Signature of Agent of Board of Health or other)
Health Officer (Official Designation)
1/27/65 (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.

JAN 27 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **15**

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. Mayflower Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Charlesina Verdy (Levett)
(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. 233 Pleasant Street
(Usual place of abode)

St. _____
(City or town and State)

Length of stay: In place of death 11 months 7 days. In place of residence 7 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 25 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Dec 5 1964 to Jan 25 1965
I last saw him alive on Jan 25 1965, death is said to
have occurred on the date stated above, at 9:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

Due To 0
(b)

Due To 0
(c)

OTHER
SIGNIFICANT
CONDITIONS 0

Was autopsy performed? Yes
What test confirmed diagnosis? Cerebral

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

(Signature) Charles F. Finner, M. D.
(Print or Type Name)

(Address) 154 Douglas St. Date 1/26 19 65

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

DATE OF BURIAL January 27 19 65

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JAN 27 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Edward Verdy
(Give maiden name of wife in full)

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

12 AGE 86 Years 3 Months 9 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) England
(State or country)

17 NAME OF FATHER Charles Levett

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

19 MAIDEN NAME OF MOTHER Margaret Baldwin

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

21 Informant Mrs. Frederick Bage

(Address) 20 Douglas 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 G. Scrammi
(Signature of Agent of Board of Health or other)

Health Officer Jan 27, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

id for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
BUL CERTIFICATE

IT OR TYPE
S OR CAUSES
O DEATH

id not enter
e than one
e for each
(a), (b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
dise, 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

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:

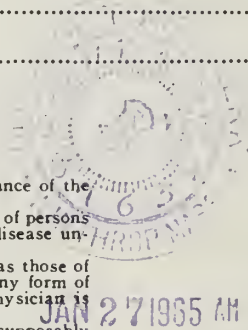
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. **16**

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 108 ALMONT

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

PHYSICIAN — IMPORTANT

2 FULL NAME MARY DOHERTY (McAULIFFE)
(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) Permanent Residence. No. 108 ALMONT
(Usual place of abode)St. WINTHROP
(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 JAN 27 1965
(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 6:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ~~Death~~ presumably due to

Due To natural causes

(b) Due To WINTHROP Board of Health

OTHER
SIGNIFICANT
CONDITIONS

Charles Liberman M.D.

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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 1/29/1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 30 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP, MASS.

Received and filed JAN 29 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

FEMALE WHITE MARRIED
WIDOWED
DIVORCED
UNKNOWN WIDOWED

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

ARTHUR T. DOHERTY

(Husband's name in full)

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

13 Usual Occupation HOME MAINTENANCE

(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) ALBURN
(State or country) MASS

17 NAME OF FATHER JOHN McAULIFFE

18 BIRTHPLACE OF FATHER (City) ROCKLAND
(State or country) ME.

19 MAIDEN NAME OF MOTHER ANNIE (NOT KNOWN)

20 BIRTHPLACE OF MOTHER (City) WORCESTER
(State or country) MASS21 Informant MRS MARY FLANNERY
(Address) 108 ALMONT ST WINTHROP.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Joseph E. Brennan
(Signature of Agent of Board of Health or other)Health Officer 1/29/65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

ed for burial permit
Board of Health
its Agent.INSTRUCTIONS
FOR
CERTIFICATEUT OR TYPE
US: OR CAUSES
OF DEATHnot enter
more than one
cause for each
(1), (b) and (c)does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
cation which causedditions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
to death but not
to the terminal
condition given

M.C.

ncil

63-936348

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.

JAN 29 1935 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 17

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

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

PHYSICIAN - IMPORTANT

Harding
Richard Hilton

2 FULL 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) Permanent Residence. No. 180 Pauline St.
(Usual place of abode)

St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death years months 17 days. In place of residence 44 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 28, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1964, to JAN 28, 1965. I last saw him alive on JAN 28, 1965, death is said to have occurred on the date stated above, at 12:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR HCT. 17 DAYS
(b) HYPERTENSION & HYPERTENSIVE CYCLES
(c) HEART DISEASE

OTHER SIGNIFICANT CONDITIONS MYOCARDIAL 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

(Signature) Myron H. King, M. D.
(Print or Type Name) MYRON H. KING M.D.
(Address) 66 North Main St. Winthrop, Mass. Date 1/29/65

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

DATE OF BURIAL January 30, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JAN 29 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

12 AGE 44 Years 4 Months 27 Days If under 24 hours Hours Minutes

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

14 Industry or Business Instrument and Optical Co.

15 Social Security No. 030-03-3542

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

17 NAME OF FATHER Philip Raymond Hilton

18 BIRTHPLACE OF FATHER (City) Wells (State or country) Maine

19 MAIDEN NAME OF MOTHER Esther Lillian Hatch

20 BIRTHPLACE OF MOTHER (City) Cambridge, Massachusetts (State or country) Massachusetts

21 Informant William P. Hilton (Address) 4800 S.W. 72nd. St. Davie, Fla.

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

Joseph C. Serrano (Signature of Agent of Board of Health or other) Joseph C. Serrano (Official Designation) Jan 29 1965 (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

ed for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

UT OR TYPE
OR CAUSES
OF DEATH

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

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

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

ditions contrib-
g death but not
e to the terminal
e disease given

M.C.

011

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.

JAN 29 1905 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Medford
(City or Town making this return)

PLACE OF DEATH

Middlesex
(County)

Medford
(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 18

No. Lawrence Mem. Hospital

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

2 FULL NAME

Paul J. Kirby

(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 II

(a) Residence. No.
(Usual place of abode)

15 Deane Ave.

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.....years.....months 8 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 28 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec 64 to Jan 28 65
I last saw him alive on Jan 28 65, death is said to
have occurred on the date stated above, at 6.35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Pulm Edema

hrs

(b) Due To Hypert. Heart disease

yrs

(c) Due To Tumor of Adrenal

yrs

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? no
If so, specify

(Signed) Peter H. Contompasis, M. D.
175 Washington St.

(Address) Winchester Date Jan 28 19 65

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

DATE OF BURIAL Feb 1, 1965 19

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop Mass.

Received and filed FEB 1 1965 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 married
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Mary E. Breen
(Give maiden name of wife in full)

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

12 39 - - If under 24 hours
AGE.....Years.....Months.....DaysHours.....Minutes

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

14 Industry or Business: Tel Co.

15 Social Security No. 022-16-6358

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

17 NAME OF FATHER Donald R. Kirby

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

19 MAIDEN NAME OF MOTHER Alice Norton

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

21 Informant Mary Kirby
(Address) 15 Dean Ave. Winthrop

A TRUE COPY

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

DATE FILED Jan 29, 1965 19

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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... Nov 5, 1942

DATE OF DISCHARGE..... Feb 9, 1946

RANK, RATING..... Gunner's Mate 3rd class

ORGANIZATION AND OUTFIT..... Navy

SERVICE NUMBER..... 202-56-52



FEB 11 1965 AM

FORM R-301

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
ALL CERTIFICATE

IT OR TYPE
S. OR CAUSES
(DEATH

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

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

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

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

M.C.

icil

-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 19

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 Charles M. Russell (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, WW2 if so specify WAR)

(a) Permanent Residence. No. 63 Harbor View Ave. St. Winthrop, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months.....7 days. In place of residence.....18 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 28 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1965, to Jan 28, 1965

I last saw him live on Jan 27, 1965, death is said to have occurred on the date stated above, at 5:55 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinoma of lung * 17 days

(b) Due To metastases to liver → not known

(c) Due To

OTHER SIGNIFICANT CONDITIONS * Pulmonary embolism

Was autopsy performed? YES Pathology report

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

(Signature) H.B. Greenfield, M. D.

(Address) 447 Smith St. Winthrop, Mass. Date 1-27-65

6 Oak Grove New Bedford (City or Town)

DATE OF BURIAL Jan. 30 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed JAN 29 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Male White MARRIED WIDOWED DIVORCED UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

12 AGE 55 Years 7 Months 3 Days If under 24 hours Hours Minutes

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

14 Industry or Business Electrical

15 Social Security No. 727-01-7229

16 BIRTHPLACE (City) New Bedford (State or country) Mass

17 NAME OF FATHER Charles A Russell

18 BIRTHPLACE OF FATHER (City) New Bedford (State or country) Mass.

19 MAIDEN NAME OF MOTHER Leah Billington

20 BIRTHPLACE OF MOTHER (City) New Bedford (State or country) Mass.

21 Informant Elizabeth Whynot

(Address) New Bedford, 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:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

April 2, 1942

October 2, 1945

Tec. Grade 4

U.S. Army

311041698

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 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.

JAN 29 1955 14

FORM R-301

 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

 STANDARD
 CERTIFICATE OF DEATH
Registered No. **20**
 PLACE OF DEATH
 I Suffolk
 Winthrop
 (County)
 (City or Town)


No. 30 Sargent Street

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

PHYSICIAN — IMPORTANT

 2 FULL NAME Alfred Carlton
 (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 Sargent Street
 (Usual place of abode)

 St. _____
 (City or town and State)

Length of stay: In place of death 48 years... months... days. In place of residence 48 years... months... days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH JAN. 29, 1965
 (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 9:00 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) natural causes.

 Due To Winthrop Board of Health
 (c)

 OTHER SIGNIFICANT CONDITIONS
 Charles Liberman, M.D.

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

(Signature) Charles Liberman, M. D.

 CHARLES LIBERMAN
 (Print or Type Name)

(Address) WINTHROP, MASS. Date 1/29/1965

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

DATE OF BURIAL February 1, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed _____, 19____.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

 11 If married, widowed, or divorced
 HUSBAND of Zoia Extensia Carter
 (Give maiden name of wife in full)

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

 12 AGE 96 Years 9 Months 2 Days If under 24 hours
 Hours... Minutes

 13 Usual Occupation retired Capt.
 (Kind of work done during most of working life)

14 Industry or Business Narrow Gage Ferries

15 Social Security No. none

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

17 NAME OF FATHER Peter Augustus Carlton

 18 BIRTHPLACE OF FATHER (City) Stockholm
 (State or country) Sweden

19 MAIDEN NAME OF MOTHER Lucy Barrett Gardner

 20 BIRTHPLACE OF MOTHER (City) Gloucester
 (State or country) Massachusetts

21 Informant Miss Lucy Barrett Carlton

(Address) 30 Sargent Street, Winthrop

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

Paul C. Gaffney, Jr.

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

Feb 1, 1965

(Date of Issue of Permit)

A TRUE COPY ATTEST:

1/8 ✓

Medical Examiner referred case to Board of Health

 for burial permit
 Board of Health
 Agent.

 INSTRUCTIONS
 FOR
 FILL CERTIFICATE

 IF OR TYPE
 S OR CAUSES
 O DEATH

 d not enter
 e than one
 e for each
 (, (b) and (c)

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

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

 Conditions contrib-
 death but not
 to the terminal
 condition given

 n.c.
 c.1

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

FEB - 1 1965 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.

d for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
L CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

does not mean
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
to the terminal
condition given

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

Cliff House Nursing Home

2 FULL NAME William Greenberg

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

(a) Permanent Residence. No. 311 Washington Avenue St. Chelsea

(Usual place of abode)

(City or town and State)

Length of stay: In place of death.....years.....2.....months.....days. In place of residence.....1.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 29 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Dec 1, 1964, to January 29, 1965I last saw him alive on Jan 28, 1965, death is said to
have occurred on the date stated above, at 6:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To (b) arteriosclerotic heart disease

Due To (c) Rheumatoid arthritis. Severe

OTHER SIGNIFICANT CONDITIONS Angina pectoris

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

(Signature) H. B. Greenfield, M. D.

(Address) 447 Shirley St. Mass Date 1-30 1965

6 Beth Israel Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 31 1965

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service

ADDRESS 151 Washington Avenue, Chelsea

Received and filed FEB 3 1965 19

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 21

{(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)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married11 If married, widowed, or divorced
HUSBAND of Evelyn L. Bloom
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 53 Years..... Months..... Days If under 24 hours
Hours..... Minutes13 Usual Occupation Salesman
(Kind of work done during most of working life)

14 Industry or Business General Merchandise

15 Social Security No. 030-16-0192

16 BIRTHPLACE (City) Somerville, Mass.
(State or country)

17 NAME OF FATHER Abraham Greenberg

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

19 MAIDEN NAME OF MOTHER Esther Feldman

20 BIRTHPLACE OF MOTHER Russia
(State or country)21 Informant Evelyn Greenberg
311 Washington Avenue, Chelsea
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Greenfield
(Signature of Agent of Board of Health or other)Health Officer January 30, 1965
(Official Designation) (Date of Issue of Permit)

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.

FEB - 21 1955

Instructions for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
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

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

ditions contrib-
death but not
to the terminal
condition given

A.C.

11

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Wintthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 22

No. 26 Plummer Avenue (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Sarah Martha Soper (Read 0)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
Reid

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

(a) Residence, No. 26 Plummer Avenue St.
(Usual place of abode) (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 January 30 1965
(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 4:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
to natural causes.

Due To (b) Winthrop Board of Health

Due To (c) Charles Liberman M.D.

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

(Signature) Charles Liberman M.D.

CHARLES LIBERMAN

(Address) WINTHROP, Mass. Date 2/1/1965

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

DATE OF BURIAL February 2, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Wintthrop St. Winthrop,

Received and filed FEB 2 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of female white
(Give maiden name of wife in full)

(or) WIFE of William Henry Soper
(Husband's name in full)

12 AGE 86 Years 6 Months 1 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) Trinity Bay
(State or country) Newfoundland

17 NAME OF FATHER James Reid

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

19 MAIDEN NAME OF MOTHER Mary Handsford

20 BIRTHPLACE OF MOTHER (City) New Foundland
(State or country)

21 Informant Arthur J. Soper

(Address) 26 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)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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

FEB - 21 1965 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.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 23

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

2 FULL NAME MARY I. (McGeach) CATES
(If deceased as 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. 100 Quincy Ave WINTHROP
(Usual place of abode)

(If nonresident, give city or town and State)

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

OR TYPE
OR CAUSES
DEATH

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

does not mean
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
do the terminal
condition given

M.C.

F. Weil

Rossine
Fitzsimmons

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 31 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Feb 11, 1965, to Jan 31, 1965I last saw him alive on Jan 31, 1965, death is said to
have occurred on the date stated above, at 11:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

INTERVAL
BETWEEN
ONSET AND
DEATH

2 hrs

Due To arteriosclerotic heart
(b) disease yrsDue To
(c)OTHER
SIGNIFICANT
CONDITIONS aneurysm of aorta yrs

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

(Signature) H. B. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Springfield St WINTHROP Date 2-1 1965

Greenwood Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb 3, 1965

7 NAME OF FUNERAL DIRECTOR W. B. CARAFA

ADDRESS 389 Washington Ave Chelsea

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of FRANK W. CATES
(Husband's name in full)12 AGE 76 Years 2 Months 22 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. None

16 BIRTHPLACE (City) Rhode Island
(State or country)

17 NAME OF FATHER John McGeach

18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)19 MAIDEN NAME OF MOTHER Rossine Fitzsimmons
McQuarry20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)21 Informant Frank W. Cates
(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)

Health Officer Feb 1, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

J.B.V.

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

FEB - 1 1935 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.

2
1173
503
503

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

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

does not mean
of dying,
heart failure,
etc. It means
the cause
which caused

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

ions contrib-
death but not
the terminal
condition given

Chapter 137,
1954, requires
ns to print or
e cause or
of death on
ificates.

C.

:1

50M-5-57-920345

PLACE OF DEATH

1

2 FULL NAME

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

(a) Residence. No. 64 Prospect Ave., St.

(Usual place of abode)

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

Registered No. 24

PHYSICIAN — IMPORTANT

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

Length of stay: In place of death 2 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 31, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

Jan., 1950, to Jan. 31, 1965

I last saw her alive on Jan. 31, 1965, death is said to

have occurred on the date stated above, at 11:10 P. m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 1/2 hr.

(b) Due To Hypertensive Arterio-
sclerotic Heart Disease 15 yrs

(c) Due To

OTHER SIGNIFICANT CONDITIONS Status-left mid High Amputee 8 yrs
GLAUCOMA 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.
(Address) WINTHROP, MASS. Date 1/31/19656 Garden Cemetery Chelsea, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 3, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed FEB 2 1965 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.

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 John J. Silva

(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.

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

17 NAME OF FATHER Robert Beard

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

19 MAIDEN NAME OF MOTHER Mary Willard

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass21 Informant Robert Silva
(Address) 64 Prospect Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (31)

(Signature of Agent of Board of Health or other)

Health Officer

Feb 2, 1965
(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 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 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

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.)

100M-9-63-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Melrose
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 25

PLACE OF DEATH

Middlesex
(County)

Melrose
(City or Town)

No. Colborne Nursing Home

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

2 FULL NAME Josephine M. Danahy
(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) Permanent Residence. No. 53 Thornton Park St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 21 years 21 months 21 days. In place of residence 30 years 30 months 30 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 15, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 21, 1964 to January 15, 1965
I last saw her alive on January 13, 1965, death is said to
have occurred on the date stated above, at 6:45 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Thrombosis 2 mos

Due To Cerebral Arteriosclerosis 5 yrs

Due To (c) 2 yrs

OTHER SIGNIFICANT CONDITIONS Senility 2 yrs

Was autopsy performed? No

What test confirmed diagnosis? Lab tests - Clinical Findings

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

(Signature) Thomas M. Hearne, M. D.

(Address) Melrose, Mass. Date Jan. 16, 1965

6 Holy Cross Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 18, 1965

7 NAME OF FUNERAL DIRECTOR Joseph Curnane

ADDRESS 516 Broadway, Everett, Mass.

Received and filed FEB 11 1965

(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
DIVORCED Single
UNKNOWN

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

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

12 AG 69 Years 3 Months 16 Days If under 24 hours
Hours Minutes

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

14 Industry or Business: Own Home

15 Social Security No. 031-03-3338

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

17 NAME OF FATHER Jeremiah Danahy

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Margaret A. Howard

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country) Ireland

21 Informant John P. Danahy (brother)

(Address) 53 Thornton Park, Winthrop, Mass.

A TRUE COPY

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

DATE FILED January 18, 1965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



FEB 11 1965 AM

for burial permit
ward of Health
ts Agent.INSTRUCTIONS
FOR
CERTIFICATEOR TYPE
OR CAUSES
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,
have rise to
cause (a),
in the under-
cause last.ditions contrib-
death but not
the terminal
condition given

81965

OUT - OF - TOWN

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

26

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

00763

x Veterans Administration Hospital

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

PHYSICIAN — IMPORTANT

2 FULL NAME Frank S. Taylor

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

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

(a) Permanent Residence. No. 55 Somerset Ave.

xx Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....12.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Jan. 8 1965 to Jan. 20 1965death is said to
have occurred on the date stated above, at 11:55A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary and cerebral embolism, 12 Days

(b) Hypertensive and arteriosclerotic

(c) heart disease with old posterior

(d) Myocardial infarction and auricular
(e) fibrillation. YearsOTHER
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

(Signature) Julian Elgator, M.D.

(Address) VAH, Boston Mass. Date Jan. 20 1965

6 Winthrop Cem., Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 22 1965

7 NAME OF FUNERAL DIRECTOR Reynolds F.H.

ADDRESS 180 Winthrop St., Winthrop, Mass.

Received and filed JAN 26 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Married
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Elizabeth Southard

(Give maiden name of wife in full)

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

12 AGE 78 Years 10 Months 11 Days If under 24 hours
Hours.....Minutes13 Usual Occupation Electrician
(Kind of work done during most of working life)

14 Industry or Business Electrical

15 Social Security No.

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

17 NAME OF FATHER William E. Taylor

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

19 MAIDEN NAME OF MOTHER Sarah Kemp

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

21 Informant V. A. Hospital Records, 150 S.

(Address) Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
has been 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:

William J. Kane.
City Registrar



FEB 18 1965 AM

for burial permit
Board of Health
its Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

oes not mean
e of dying,
heart failure,
etc. It means
te, or compli-
which caused

ons, if any,
have rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
the terminal
condition given

OUT - OF - TOWN

SUFFOLK

(County)

ROXBURY

(City or Town)

PLACE OF DEATH

No. JEWISH MEMORIAL HOSPITAL

2 FULL NAME REBECCA MALINSKY

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

(a) Permanent Residence. No. 35 NEVADA ST.

(Usual place of abode)

St. WINTHROP, MASS.

(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 30, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from JANUARY 5, 1965, to JANUARY 30, 1965

I last saw him alive on JANUARY 30, 1965, death is said to have occurred on the date stated above, at 8:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA, GENITAL ORGANS

(b) Due To FISTULA, RIGHT LOWER ABDOMEN

(c) Due To

OTHER SIGNIFICANT CONDITIONS

GENERALIZED

ARTERIO SCLEROSIS

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

(Signature) P. Perez Diaz, M. D.

P. PEREZ DIAZ

(Print or Type Name)

(Address) JEWISH MEM. HOSP. Date JAN. 30, 1965

6 Tifereth Israel of Winthrop, Everett

Place of Burial or Cremation

January 31, 1965

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service

ADDRESS 151 Washington Avenue, Chelsea

Received and filed FEB 3 1965

William J. Kane

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

27

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 01233

(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)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of Hyman Malinsky (Give maiden name of wife in full) (Husband's name in full)

12 AGE 64 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. none

16 BIRTHPLACE (City) Russia (State or country)

17 NAME OF FATHER Samuel Cooper

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

19 MAIDEN NAME OF MOTHER Lena (CBL)

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

21 Informant Hyman Malinsky 35 Nevada Street, Winthrop

(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) 13377 1-31-65

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane

City Registrar

MAR 1 1965 PM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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

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

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

ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk
(County)Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No.

28

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 Sohl Sparer
(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 2

(a) Permanent Residence. No. 29 Tewksbury St.
(Usual place of abode)

St. Winthrop, Mass

(City or town and State)

Length of stay: In place of death years months 2 days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 1 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN 30, 1965 to Feb 1, 1965I last saw him live on Jan. 31, 1965, death is said to
have occurred on the date stated above, at 7:20 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart

(b) Disease

(c) Due To

OTHER SIGNIFICANT CONDITIONS Anasarca

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(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 2/1/65

6 Golden Crown Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 2, 1965

7 NAME OF FUNERAL DIRECTOR Stanetsky Memorial Chapel
Benjamin Birnbach

ADDRESS 10 Washington St., Dorchester

Received and filed FEB 2 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

12 AGE 47 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Wildlife & Fish Dept.
(Kind of work done during most of working life)

14 Industry or Business U.S. Gov't.

15 Social Security No. 031-22-2079

16 BIRTHPLACE (City) Somerville, Mass.
(State or country)

17 NAME OF FATHER Nathan Sparer

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

19 MAIDEN NAME OF MOTHER Gertrude Pearlmutter

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

21 Informant Nathan Sparer

(Address) 29 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:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... November 6, 1942

DATE OF DISCHARGE..... December 3, 1945

RANK, RATING..... P.F.C.

ORGANIZATION AND OUTFIT..... Med Detach. 101st Inf. U.S. Army

SERVICE NUMBER..... 31226600

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.

FEB - 21 1946

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 29

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

(a) Permanent Residence. No. 74 Orlando Ave St. _____
(Usual place of abode) (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 3 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN 29, 1963, to FEB 3, 1965
I last saw her live on FEB 3, 1965, death is said to
have occurred on the date stated above, at 4:15 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCT. 3 DAYS

Due To (b) ARTERIO SCLEROTIC HEART DIS

Due To (c) AND GENERAL ARTERIO SCLEROSIS 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 _____

(Signature) Myron H. King, M. D.
MYRON H. KING M.D.
(Print or Type Name)
(Address) WINTHROP MASS Date 2/4 1965

6 Forest Dale Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 6 1965

7 NAME OF FUNERAL DIRECTOR Charles E. D. Margeson
839 Main St. Malden, Mass.

ADDRESS _____
Received and filed FEB 4 1965 19 _____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of Harry M. Forsaith
(Give maiden name of wife in full)
(Husband's name in full)

12 85 If under 24 hours
AGE 85 Years _____ Months _____ Days _____ Hours _____ Minutes

13 Usual Occupation Hotel Mgr.
(Kind of work done during most of working life)

14 Industry or Business Standish Hotel, Worcester, Mass.

15 Social Security No. 005-16-8978

16 BIRTHPLACE (City) Hunts Cty. N.S.
(State or country)

17 NAME OF FATHER George B. Vaughan

18 BIRTHPLACE OF FATHER (City) N.S.
(State or country)

19 MAIDEN NAME OF MOTHER Angeline Greenough

20 BIRTHPLACE OF MOTHER (City) N.S.
(State or country)

21 Informant Myra Thurman
74 Orlando Ave. Winthrop, Mass.
(Address)

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

Paul C. Safford
(Signature of Agent of Board of Health or other)
Health Officer Feb 4 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Vibe

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.

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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.

FEB - 4 1935 AM

ed for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
CERTIFICATE

IT OR TYPE
S OR CAUSES
C DEATH

d not enter
e than one
e for each
(, (b) and (c)

does not mean
e of dying,
heart failure,
etc. It means
dise, or compli-
ions which caused
h.

omions, if any,
hic gave rise to
ou cause (a),
ati the under-
in, cause last.

ditions contrib-
g death but not
ed to the terminal
se condition given
s).

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. Bayview Nursing Home

2 FULL NAME Ruth Amelia Henricksen (Swimm)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 281 Princeton St. East Boston, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death. 2 years. 2 months. 14 days. In place of residence. 50 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 4 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
MAY 1960 to February 4, 1965
I last saw her alive on Feb 3, 1965, death is said to
have occurred on the date stated above, at 8 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHO PNEUMONIA

Due To MYOCARDIAL HEART DIS.

Due To
(c)

OTHER SIGNIFICANT CONDITIONS CEREBRAL THROMBOSIS 2 YS

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

(Signature) Louis F. Salerno, M. D.

(Print or Type Name)

(Address) WINTHROP MASS Date FEB 4 1965

6 Woodlawn Cemetery Everett
Place of Burial or Cremation (City or Town) Mass.

DATE OF BURIAL February 6 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

199 Wintrop St. Winthrop, Mass

ADDRESS

Received and filed FEB 8 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop, Mass.
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 30

(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)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Thomas William Henricksen
(Husband's name in full)

12 AGE 67 Years 5 Months 26 Days If under 24 hours
Hours Minutes

13 Usual Occupation Wholesale Millinery Store
(Kind of work done during most of working life)

14 Industry or Business Milliner

15 Social Security No. 011 05 9296

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

17 NAME OF FATHER Herbert M. Swimm

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

19 MAIDEN NAME OF MOTHER Amelia Van Norton

20 BIRTHPLACE OF MOTHER (City) Port Clyde, Nova
(State or country) Scotia, Canada

21 Informant Thomas W. Henricksen
281 Princeton St.

(Address) 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:

Paul C. Gaffney (3)
(Signature of Agent of Board of Health or other)

Health Officer Feb 6 1965
(Official Designation) (Date of Issue of Permit)

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 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.

81965 AM

The Commonwealth of Massachusetts

OUT - OF - TOWN

JOSEPH D. WARD

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

01456

Registered No.

PLACE OF DEATH

Suffolk
(County)Boston
(City or Town)STANDARD
CERTIFICATE OF DEATH

No. Hebrew Home For Aged

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

PHYSICIAN - IMPORTANT

2 FULL NAME

David ARKIN

(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 Quincy Avenue

St.

Winthrop

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 6 years 8 months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHFeb 6
(Month)6
(Day)1965
(Year)

4 I HEREBY CERTIFY, That I attended deceased from

June 26, 1955, to Feb 6, 1965

I last saw him alive on Feb 6, 1965, death is said to
have occurred on the date stated above, at 5:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

Due To

(b)

Pulmonary Emphysema

Due To

(c)

OTHER

SIGNIFICANT
CONDITIONS

Parkinson's Disease

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) Harry A. Smith, M. D.

Hebrew A. S. R. P. 2

(PRINT OR TYPE SIGNATURE)

(Address) 1265 Beacon Date Feb 7 1965

6 Tifereth Israel of Winthrop Everett

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Feb 7

1965

7 NAME OF

FUNERAL DIRECTOR

Torg Funeral Serv. Inc.

ADDRESS

151 Washington Ave Chelsea

Received and filed

FEB 10 1965 FEB 14 1965

(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

Sophie Tavin

(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

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation: Foreman

(Kind of work done during most of working life)

14 Industry

or Business: Coal Business

15 Social Security No.

CBL

16 BIRTHPLACE (City)

(State or country)

Russia

17 NAME OF
FATHER

Nochum ARKIN

18 BIRTHPLACE OF

FATHER (City)

(State or country)

RUSSIA

19 MAIDEN NAME

OF MOTHER

Fannie C.B.L.

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

RUSSIA

21

Informant

(Address)

Samuel ARKIN

54 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 or Board of Health or other)

13594 J-163

Official Designation

(Date of Issue of Permit)

X

R-301A

CTIONS
FOR
CERTIFICATEgiving
OF DEATHnt enter
than one
for each
b) and (c)es not mean
of dying,
heart failure,
tc. It means
or compli-
which causedas, if any,
ve rise to
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he 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
ter signature.50
1965
70

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

MAR 1 1885 PM

and for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not 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 caused

ions, if any,
in gave rise to
n cause (a),
the under-
n cause last.

ditions contrib-
death but not
o the terminal
e: condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. **32**

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. **14 Seymour Street** St. (If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME **Mona B. Duffy**
(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. **14 Seymour Street** St.
(Usual place of abode) (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 **February 6, 1965**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
11-21, 19**52**, to **2-6-65**, 19**65**.I last saw **her** alive on **2-4**, 19**65**, death is said to
have occurred on the date stated above, at **1 a.** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Bronchopneumonia** **5 days**Due To **Parkinson's disease** **9 yrs**(b) **Generalized arterio-**
(c) **sclerosis** **13 yrs**OTHER SIGNIFICANT CONDITIONS **Arteriosclerotic heart disease** **10 yrs**Was autopsy performed? **no**What test confirmed diagnosis? **clinical & lab**5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify(Signature) **M. Traunstein, Jr.**, M. D.**M. Traunstein, Jr., M.D.**
(Print or Type Name)(Address) **73 Bartlett Rd. 2-6-65**
Winthrop, Mass.6 **Winthrop Winthrop Mass**
Place of Burial or Cremation (City or Town)DATE OF BURIAL **February 9, 1965**7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**ADDRESS **Winthrop, Mass**Received and filed **FEB 8 1965** 19**65**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED Married
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of(or) WIFE of **Joseph F. Duffy**
(Give maiden name of wife in full)
(Husband's name in full)12 AGE **72** Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: **Housewife**
(Kind of work done during most working life)14 Industry or Business: **Own Home**

15 Social Security No.

16 BIRTHPLACE (City).....**Cambridge**
(State or country) **Mass**17 NAME OF FATHER **William Thompson**18 BIRTHPLACE OF FATHER (City).....**Cannot be learned**
(State or country)19 MAIDEN NAME OF MOTHER **Mona Hayman**20 BIRTHPLACE OF MOTHER (City).....**Cannot be learned**
(State or country)21 Informant **Joseph F. Duffy**
(Address)**14 Seymour St., Winthrop**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:**Pave C. Gaffney**
(Signature of Agent of Board of Health or other)**Keith Glean** **Feb 8, 1965**
(Official Designation) (Date of Issue of Permit)

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 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.

FEB 9 1965 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-6-62-933404

PLACE OF DEATH

Middlesex
(County)
Framingham
(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Framingham
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 33

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

2 FULL NAME Theresa Moran (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. 125 Cliff Ave. St. Winthrop Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death 6 years 10 months 12 days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 6, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 25 58 to February 6 65. I last saw her alive on February 6 1965, death is said to have occurred on the date stated above, at 5:36 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia 48 Hrs. INTERVAL BETWEEN ONSET AND DEATH

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Hypertension

Was autopsy performed? no What test confirmed diagnosis? clinical findings

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

(Signature) H. Emerson Thomas, Jr., M. D.

(Address) Cushing Hosp. Date 2/6 19 65

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

DATE OF BURIAL February 10 19 65

7 NAME OF FUNERAL DIRECTOR Caggiano Funeral Home

ADDRESS Winthrop, Mass.

Received and filed MAR 1 1965 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 DIVORCED UNKNOWN single

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

12 AGE 80 1 3 Days If under 24 hours Hours Minutes

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

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Ireland (State or country)

17 NAME OF FATHER Thomas Moran

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

19 MAIDEN NAME OF MOTHER Elizabeth Kennedy

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

21 Informant Medical Records Office Cushing Hosp. Framingham, Mass. (Address)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred) February 8 65

DATE FILED February 8 19 65

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.

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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.



21265 AP

d for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
L CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

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

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

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gave rise to
cause (a),
on the under-
cause last.

ditions contrib-
death but not
the terminal
condition given

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ci.1

X
PLACE OF DEATH
1

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 34

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

PHYSICIAN — IMPORTANT

2 FULL NAME Rebecca Hurst
(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) Permanent Residence. No. 21 Sturgis St. St. Winthrop
(Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months 1 days. In place of residence 6 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 7 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
May 1963, to February 7, 1965
I last saw her alive on Feb. 6, 1965 death is said to
have occurred on the date stated above, at 5:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

(b) Arteriosclerosis - gen

(c) Myocardial Heart Disease

INTERVAL
BETWEEN
ONSET AND
DEATH
12 hr

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? ERG

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

(Signature) Joseph C. F. GORIE M. D.

(Address) 194 Washington Ave. Chelsea
(Print or Type Name) Date 2/7/65

6 Will St Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 8 1965

7 NAME OF FUNERAL DIRECTOR T. F. Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed FEB 11 8 1965 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Divorced UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of HARRY HURST
(Husband's name in full)

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

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

14 Industry or Business GARMENT INDUSTRY

15 Social Security No. 4-3

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER SURMAN

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 Albert Sherman
(Address) 296 River Rd 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 Feb 11 1965
(Official Designation) (Date of Issue of Permit)

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

FEB - 8 1935 AM

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

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(for burial permit
of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

es not mean
of dying,
heart failure,
etc. It means
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e.1

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 35

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 John Francois Vranken
(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 Tilestone Road st. Winthrop, Massachusetts
(Usual place of abode) (City or town and State)

Length of stay: In place of death. years. months. 6 days. In place of residence 12 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 8, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan. 26, 1965, to Feb. 8, 1965.

I last saw him alive on Feb. 6, 1965, death is said to
have occurred on the date stated above, at 7:35am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastro Intestinal Hemorrhage

Due To (b) Arteriosclerosis

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic heart disease 2 yrs.
Diabetes Mellitus 5 yrs.

Was autopsy performed? no

What test confirmed diagnosis? clinical findings

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

(Signature) John F. Collins M.D.

John F. Collins, M.D.
(Print or Type Name)

(Address) 27 Bennington Street, Feb. 8, 1965

Revere, Mass.

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

DATE OF BURIAL February 11, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed Feb. 12, 1965 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED divorced
DIVORCED married
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Impi M. (Hirvela) Vranken
(Give maiden name of wife in full)

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

12 AGE 72 years 3 Months 5 Days If under 24 hours
Hours Minutes

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

14 Industry or Business Restaurant Business

15 Social Security No. 030 09 6014

16 BIRTHPLACE (City) Louvieu, Belgium
(State or country)

17 NAME OF FATHER Franz Vranken

18 BIRTHPLACE OF FATHER (City) Louvieu, Belgium
(State or country)

19 MAIDEN NAME OF MOTHER Marie Vrebosch

20 BIRTHPLACE OF MOTHER (City) Louvieu, Belgium
(State or country)

21 Informant Alice Virginia De Corte

(Address) 19 Tilestone Rd. Winthrop

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

Paul C. Gaffney (over)
(Signature of Agent of Board of Health or other)

Health Officer 2/11/65
(Official Designation) (Date of Issue of Permit)

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:

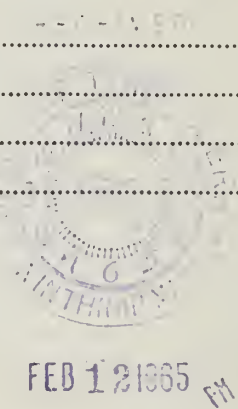
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
b) and (c)

es not mean
of dying,
heart failure,
tc. It means
n, or compli-
which caused

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the under-
ause last.

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death but not
the terminal
condition given

2.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

No. 17 Trident Avenue

STANDARD
CERTIFICATE OF DEATH

Registered No. 36

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

2 FULL NAME **Fannie Lundy**
(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) Permanent Residence. No.
(Usual place of abode)

17 Trident Avenue

St.

(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 **Feb 9, 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan. 1950 to Feb. 9, 1965

I last saw he alive on **Feb 4, 1965** death is said to
have occurred on the date stated above, at **11:00 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Acute Coronary Occlusion**(b) **Hypertensive - Coronary**(c) **Artery Heart Disease**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

(Signature) **Charles Liberman**, M. D.**CHARLES LIBERMAN**

(Print or Type Name)

(Address) **WINTHROP, MASS.** Date **2/9/1965**

6 **Ind. Workmens Circle, West Roxbury**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Feb 10, 1965**7 NAME OF FUNERAL DIRECTOR **Torf Funeral Service Inc****151 Washington Avenue, Chelsea**ADDRESS **FEB 10 1965**

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)
Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of **Max Lundy**

(Husband's name in full)

12 AGE **80** 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. **none**16 BIRTHPLACE (City) **Russia**
(State or country)17 NAME OF FATHER **Sam Sirota**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 **Marilyn Feldman**
11 Mandalay Road, Newton

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

Paul C. Goffney

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

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 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.

FEB 1 0 10 35 PM



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.

PLACE OF DELIVERY

SUFFOLK

(County)

WINTHROP

(City or Town)

No.

WINTHROP COMMUNITY HOSPITAL

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

Registered No.

37

St.

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

2 NAME OF FETUS BABY BOY HOGAN
(if given)

3 DATE OF DELIVERY Feb 10 1965
(Month) (Day) (Year)

4 SEX Male ☒ Female ☐ Undetermined ☐

5 COLOR (if determined) wh

6 THIS BIRTH (Check one)
Single ☒ Twin ☐ Triplet ☐

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

FATHER

8 FULL NAME

Frederick A. Hogan

9 RESIDENCE, NO. 65 Loring Rd. STREET
CITY OR TOWN Winthrop STATE Mass.

10 COLOR OR RACE wh 11 AGE AT TIME OF THIS DELIVERY 40 (Years)

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

13 OCCUPATION Salesman

MOTHER

14 MAIDEN NAME

McIlhanny, Kathleen

PRESENT NAME

Kathleen Hogan

15 RESIDENCE, NO. 65 Loring Rd STREET
CITY OR TOWN Winthrop STATE Mass.

16 COLOR OR RACE wh 17 AGE AT TIME OF THIS DELIVERY 36 (Years)

18 PLACE OF BIRTH Philadelphia, Pa.
(City or Town) (State or country)

19 INFORMANT Frederick A. HOGAN

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? 0

21 LENGTH OF PREGNANCY completed weeks 38

22 Weight Lb. 5 Oz. 0
(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) stillborn

Due To (b) abruptio Placenta

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 WINTHROP Cem. WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL FEB 11 1965

27 NAME OF FUNERAL DIRECTOR RICHARD C. KIRBY INC
ADDRESS 917 BENNINGTON ST. EB

Received and filed FEB 11 1965 19.....

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 6:58 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

A. Paul DerHagopian M.D.

A PAUL DERHAGOPIAN, M.D.
(PRINT OR TYPE NAME)

Address 39 LARY AV. HELSEA Date Feb 11 1965

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

Paul C. Gaffney
(Signature of Agent of Board of Health or other)

Health Officer Feb 11 1965
(Official Designation) (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.

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
DEATH CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

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

ditions, if any,
which have rise to
the cause (a),
in the under-
lying cause last.

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

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 173 Pauline Street

2 FULL NAME Robert Barclay

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

173 Pauline Street

(a) Permanent Residence. No.
(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death 82 years.....months.....days. In place of residence 32 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 13 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
MAR 6 1956 to FEB 13 1965I last saw him live on FEB 13 1965, death is said to
have occurred on the date stated above, at 7:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY OCCLUSION

INTERVAL
BETWEEN
ONSET AND
DEATH

10 MIN.

(b) Due To ARTERIO SCLEROTIC HEART DIS

(c) Due To NEPHRO SCLEROSIS

OTHER SIGNIFICANT CONDITIONS PROSTATIC HYPERTROPHY
WITH OBSTRUCTION
UREMIA - PARTIAL

2 MO

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL TESTS, X-RAYS

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

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

MYRON N. KING

(Print or Type Name)

(Address) 123 Pleasant St. Date 2/14 1965

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

DATE OF BURIAL Feb. 16 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed FEB 15 1965 19.

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

38

{(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
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Ruphie Pendleton
(Give maiden name of wife in full)

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

12 AGE 92 Years 10 Months 18 Days
If under 24 hours
Hours Minutes13 Usual Occupation Engineer
(Kind of work done during most of working life)

14 Industry or Business Retail Store

15 Social Security No. 012-10-3665

16 BIRTHPLACE (City) Liverpool
(State or country) England

17 NAME OF FATHER Peter Barclay

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

19 MAIDEN NAME OF MOTHER Margaret Trotter

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

21 Informant Edward A Barclay

(Address) 35 Court 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:Paul C. Heston
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

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

FEB 15 1935 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.

FORM R-301

1 for burial permit
Board of Health
its Agent.

DUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

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heart failure,
etc. It means
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which caused

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ause last.

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to eath but not
the terminal
condition given

2.

2.3.1

2-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 39

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 36 Madison Avenue

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

PHYSICIAN — IMPORTANT

2 FULL NAME Edward Ernest May
(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. 36 Madison Avenue st. Winthrop, Massachusetts
(Usual place of abode) (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 14 1965
(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 4:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due To Natural causes.

(c) Due To Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman, M.D.

Was autopsy performed? NO

What test confirmed diagnosis?

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

(Signature) Charles Liberman, M.D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 2/15/1965

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

DATE OF BURIAL February 17, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed FEB 17 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Emily Witham
(Give maiden name of wife in full)

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

12 AGE 38 Years 1 Months 15 Days If under 24 hours
Hours.....Minutes

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

14 Industry or Business Charlestown Navy Yard

15 Social Security No. 022-07-5491

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

17 NAME OF FATHER Edward Ernest May

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

19 MAIDEN NAME OF MOTHER Martha Jones

20 BIRTHPLACE OF MOTHER (City) New Foundland
(State or country)

21 Informant Mrs. Edward E. May

(Address) 36 Madison Ave Winthrop

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

Paul C. Giffney
(Signature of Agent of Board of Health or other)

Death Officer February 17, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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

FEB 17 1935 PM

RULES OF PRACTICE

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

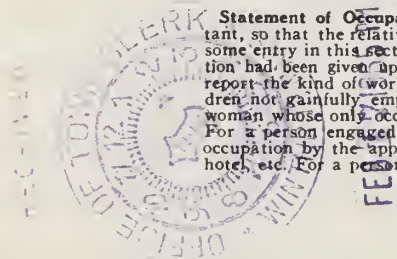
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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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.



M R-301

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Mayflower Nursing Home

The Commonwealth of Massachusetts

KEVIN H. WHITE
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.

40

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

2 FULL NAME Mary Ann Smith

(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. 28R Mt. Vernon St.,
(Usual place of abode)St. Somerville, Mass.
(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, 11 years, 11 months, 11 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 15 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
11:00 A.M. 5, 1965, to Feb. 15, 1965.I last saw her alive on Feb. 14, 1965, death is said to
have occurred on the date stated above, at 11:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Broncho-pneumonia

INTERVAL
BETWEEN
ONSET AND
DEATH
6 daysDue 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 J. Ferreira, M.D.
Charles J. Ferreira
(Print or Type Name)

(Address) 67 Beppington St. Date 2/17 1965

6 Holy Cross, Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 19 1965

7 NAME OF DIRECTOR Andrews & Reed Inc.

ADDRESS 323 Broadway, Cambridge, Mass.

Received and filed FEB 17 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 CITIZEN OF U.S. YES [X] NO [] 11 SINGLE [] MARRIED [X] WIDOWED [X] DIVORCED [] UNKNOWN []

11a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William J. Smith
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 38 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation: Housewife - At home
(Kind of work done during most of working life)

15 Industry or Business: - -

16 Social Security No.

17 BIRTHPLACE (City) Ireland
(State or country)

18 NAME OF FATHER Patrick Brennan

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

20 MAIDEN NAME OF MOTHER Mary Cryan

21 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)22 Informant William F. Smith
(Address) 7 Fountain Ave., SomervilleI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Goffney Jr.
(Signature of Agent of Board of Health or other)Health Officer Feb 17 1965
(Official Designation) (Date of Issue of Permit)

6-930213

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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for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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

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

conditions, if any,
which have rise to
the cause (a),
the underlying
cause lost.

conditions contrib-
uted to death but not
the terminal
condition given

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME

Lawrence Berry <20>

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

(a) Permanent Residence. No.

(Usual place of abode)

83 St. Andrew Road

St. East Boston, Mass.

(City or town and State)

Length of stay: In place of death.....years.....1 month, 24 days. In place of residence.....40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from May 1960, to Feb 16 1965

I last saw him alive on Feb 15 1965. Death is said to have occurred on the date stated above, at 5:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia (terminal)
(b) Carcinoma of liverDue To
(c)OTHER
SIGNIFICANT
CONDITIONS

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

(Signature) Joseph Eugene M. D.

Joseph GREGORIE

(Address) 194 Washington Ave. Date 2/16 1965

6 BURITAN LAWN MEM. PK. WEST PEABODY
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB. 19, 1965

7 NAME OF FUNERAL DIRECTOR RICHARD CIGBY INC.

ADDRESS 917 BENNINGTON ST. E.B.

Received and filed FEB 16 1965 19.

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

37 41

(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

M

9 COLOR

W.

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced

HUSBAND OF CARMELA LABADESSA
(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 58 Years 10 Months 7 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation DENTAL SERVICE MAN
(Kind of work done during most of working life)

14 Industry or Business

S.S. WHITE CO

15 Social Security No.

021-01-3766

16 BIRTHPLACE (City)

Italy

(State or country)

17 NAME OF

FATHER

EUGENE LABADESSA

18 BIRTHPLACE OF

FATHER (City)

ITALY

(State or country)

19 MAIDEN NAME

OF MOTHER

NANCY (CBL)

20 BIRTHPLACE OF

MOTHER (City)

ITALY

(State or country)

21 Informant

MRS. CARMELA BERRY-WIFE

(Address)

83 ST. ANDREW 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:

-Paul C. Gaffney, Inc.

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

2/16/65

(Date of Issue of Permit)

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 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.

1 R-303

for burial permit
Board of Health
its Agent.

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.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

24 Beacon St., Winthrop

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

ESTHER Louise MOLOZNIK (Eldridge)

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

Registered No. 42

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

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 16, 1965
(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.)
Laennec's cirrhosis of liver.
Hepatic 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, _____

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

(Address) Boston (Print or Type Name) 2/18 65

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

DATE OF BURIAL February 19, 1965

8 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop, Mass.

Received and filed FEB 23 1965 _____ 19 _____

A TRUE COPY ATTEST:

(Registrar)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH(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

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

12 If married, widowed, or divorced

HUSBAND of _____ (Give maiden name of wife in full)

(or) WIFE of John J. Moloznik (Husband's name in full)

13 AGE 52 Years 18 Months 15 Days If under 24 hours _____ Hours _____ Minutes

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

15 Industry or Business: own home

16 Social Security No. 033-14-9956

17 BIRTHPLACE (City) Nantucket Island (State or country) Massachusetts

18 NAME OF FATHER Arthur C. Eldridge

19 BIRTHPLACE OF FATHER (City) Nantucket Island (State or country) Massachusetts

20 MAIDEN NAME OF MOTHER Susan A. Parker

21 BIRTHPLACE OF MOTHER (City) Boston (State or country) Massachusetts

22 Informant Mrs. Mary O. Batchelder (Address) 42 Sunnyside Ave., Winthrop

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

Paul C. Goffney (B) (Signature of Agent of Board of Health or other)

Health Officer February 9, 1965 (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 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.)"

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

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

ions, if any,
have rise to
cause (a),
the under-
cause last.

ditions contrib-
to death but not
the terminal
condition given

2.

icil

Medical Examiner Referred Case to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

43

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 14 Winthrop Street

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

PHYSICIAN — IMPORTANT

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

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

(a) Permanent Residence, No. 14 Winthrop St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 40 years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 18 1965
(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 6:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

(b) Due To natural causes.

(c) Due To Winthrop Board of Health
Charles Liberman M.D.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

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS. (Print or Type Name)
Date 2/19/1965

6 St. Joseph's Boston, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 20, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
Winthrop, Mass

ADDRESS

Received and filed 2-19-1965 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

(or) WIFE of Joseph C. Naulty
(Husband's name in full)

12 AG 83 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)
(State or country) Galway, Ireland

17 NAME OF FATHER Lawrence Conroy

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

19 MAIDEN NAME OF MOTHER Mary A. O'Connor

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

21 Informant Gorman, Voss, Brodbine Atty's

(Address) 73 Tremont St., Boston, Mass

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

Paul C. Gaffney (3)
(Signature of Agent of Board of Health or other)
Health Officer Feb 19, 1965
(Official Designation) (Date of Issue of Permit)

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 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.

FEB 19 1935



PH 111



The Commonwealth of Massachusetts

KEVIN H. WHITE

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. 44

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
(if given)

Baby Boy Sardina

3 DATE OF
DELIVERY

2/ 18/ 65

(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

John J. Sardina

9 RESIDENCE, NO.

28 True St.

STREET

CITY OR TOWN

Revere,

STATE

Mass.

10 COLOR OR
RACE

White

11 AGE AT TIME OF
THIS DELIVERY

30

(Years)

12 PLACE OF
BIRTH

Boston, Mass.

(City or Town)

(State or country)

13 OCCUPATION

Sheet Metal Worker

MOTHER

14 MAIDEN NAME

Phyllis Della Porta

PRESENT NAME

Phyllis Sardina

15 RESIDENCE, NO.

28 True St.

STREET

CITY OR TOWN

Revere,

STATE

Mass.

16 COLOR OR
RACE

White

17 AGE AT TIME OF
THIS DELIVERY

31

(Years)

18 PLACE OF
BIRTH

Revere,

Mass.

(City or Town)

(State or country)

19 INFORMANT

John J. Sardina

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

2

(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?

0

21 LENGTH OF
PREGNANCY
completed weeks

40 1/2

22 Weight Lb. 5 Oz. 10
OF FETUS
(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)

5 drops of lead & neck

Due To (b)

0 amniotic embolism

Due To (c)

unknown

OTHER SIGNIFICANT
CONDITIONS

none

26

Place of Burial or Cremation

FALLS CROSS Malden
(City or Town)

DATE OF BURIAL

2/19/65

19

27 NAME OF
FUNERAL DIRECTOR

ADDRESS

773 Broadway Revere

Received and filed

19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 2⁰⁶ A. M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Jacob B. Burke

M.D.

JACOB B. BURKE M.D.

(PRINT OR TYPE NAME)

42 CRESCENT AVE
Address
CHELSEA MASS

Date 2/18/65

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

Paul C. Gaffney

(Signature of Agent of Board of Health or other)

Health Officer

Feb 19, 1965

(Official Designation)

(Date of Issue of Permit)



FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
FEB 18 1965 AM
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.

R-301A

CTIONS
OR
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F DEATH

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or compli-
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use (a),
e under-
use last.

thus contrib-
ath but not
to the terminal
condition given

apter 137,
ll, requires
to print or
he cause or
e of death on
ificates.

50M-1-58-921876

PLACE OF DEATH

1

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.

45

No. MAYFLOWER NURSING HOME 39 GROVENS St. (If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME Rose Chandler (CURLEY) (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. 19 LEWIS AVE WINTHROP St. (If nonresident, give city or town and State)

Length of stay: In place of death 3 years 6 months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 19 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
, 1950, to Feb. 19, 1965
I last saw her alive on Feb. 17, 1965, death is said to
have occurred on the date stated above, at 11:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarct
Disease

Due To (b) arteriosclerosis
gen

Due To (c)

OTHER SIGNIFICANT CONDITIONS cerebro-vascular
accident

Was autopsy performed?

What test confirmed diagnosis?

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

(Signed) Joseph Grover M. D.

(Address) 194 Washington Ave Date 2/19/65

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 23 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY
ADDRESS WINTHROP

Received and filed FEB 23 1965 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 GEORGE F. CHANDLER
(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: HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No. 221-24-4914

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

17 NAME OF FATHER PATRICK CURLEY

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

19 MAIDEN NAME OF MOTHER AGNES COYNE

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

21 Informant GEORGE F. CHANDLER
(Address) 73 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:

(Signature of Agent of Board of Health or other)

Health Officer Feb. 23, 1965
(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 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 purpose 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 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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Cambridge
(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)



COPY OF
CERTIFICATE OF DEATH

Registered No. 295

46

No. Holy Ghost Hospital

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

2 FULL NAME Joseph Petrucci

(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) Permanent Residence. No. 45 Waldemar Ave.
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....19 days. In place of residence 52 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 23, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 4, 1965 to Feb. 23, 1965
I last saw him alive on Feb. 23, 1965, death is said to
have occurred on the date stated above, at 1:45 p.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Bilateral Bronchopneumonia

(b) Multiple cerebral vascular
accidents with left hemiplegia

(c) Due To

OTHER SIGNIFICANT CONDITIONS Generalized arterio-sclerosis.

Was autopsy performed? no

What test confirmed diagnosis?

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

(Signature) John F. Lee, M. D.

(Address) Holy Ghost Hosp. 2-23 65

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

DATE OF BURIAL Feb. 26, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
Winthrop, Mass.

ADDRESS

Received and filed MAR 2 1965

(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
DIVORCED Married
UNKNOWN

11 If married, widowed or divorced
HUSBAND of Elizabeth Mancuso
(Give maiden name of wife in full)

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

12 AGE 79 Years.....Months.....Days
If under 24 hours
Hours.....Minutes

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

14 Industry or Business: Tailoring

15 Social Security No.

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Vincenzo Petrucci

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

19 MAIDEN NAME OF MOTHER Maria Martini

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

21 Informant Edith Violette
(Address) 45 Waldemar Ave. Winthrop

A TRUE COPY

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

DATE FILED Feb. 24, 1965

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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

MAR 1 1935 PM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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for each
(b) and (c)

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of dying,
heart failure,
etc. It means
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which caused

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cause (a),
the under-
ause last.

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to death but not
the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 47

No. WINTHROP COMMUNITY HOSPITAL

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

Margery (Joy) Belcher

PHYSICIAN — IMPORTANT

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

15 INGLESIDE AVE.,

St. WINTHROP

(a) Permanent Residence. No.
(Usual place of abode)

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 26 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

Mar 63, 1963, to Feb 26, 1965

I last saw her alive on Feb 26, 1965, death is said to
have occurred on the date stated above, at 8:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

(b) Arteriosclerosis generalized

(c) Diabetes mellitus

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

(Signature) Joseph P. Gregoire, M. D.

Joseph P. Gregoire

(Address) 19460 Ingleside Ave. 2/26/1965

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

DATE OF BURIAL March 1 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed 3-1-65 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Harold P Belcher

(Husband's name in full)

12 AGE 72 Years 6 Months 12 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. 011-05-1847

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

17 NAME OF FATHER Daniel Joy

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country)

19 MAIDEN NAME OF MOTHER Alice Hathaway

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)

21 Informant Richard Belcher

(Address) 15 Ingleside Ave. Winthrop

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

Paul C. Gaffney (B)

(Signature of Agent of Board of Health or other)

Health officer March 1, 1965

(Official Designation) (Date of Issue of Permit)

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 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.



MAR - 1 1965 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 48

No. Bay View Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Patrick Henry 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) No

59 St. Andrew Road

East Boston, Mass.

(a) Residence. No.
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 1 years... months... days. In place of residence 19 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 27 - 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Feb. 29, 1964, to Feb. 27, 1965
I last saw him alive on Feb. 20, 1965 death is said to
have occurred on the date stated above, at 12 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIOMINAL Aortic Aneurysm

Due To (b) Atherosclerosis

Due To (c)

OTHER SIGNIFICANT CONDITIONS Uremia Severe

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

(Signature) Charles Meloni, M. D.

C. H. A. R. L. E. S. M. E. L. O. N. I.
(Print or Type Name)

(Address) 45 Baywater St. E. Boston Date 7/2/65

6 Holy Cross - Malden, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 2, 1965

7 NAME OF FUNERAL DIRECTOR JOSEPH A. CARR

ADDRESS 350 Broadway, Everett, Mass.

Received and filed MAR 1 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed or divorced
HUSBAND of Alice (Unknown) Sullivan
(Give maiden name of wife in full)

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

12 AGE 79 Years... Months... Days If under 24 hours
Hours... Minutes

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

14 Industry or Business Pleasant Park Yacht Club

15 Social Security No. 03-05-7887A

16 BIRTHPLACE (City) Newport,
(State or country) Rhode Island

17 NAME OF FATHER Maurice Sullivan

18 BIRTHPLACE OF FATHER (City) Thomaston,
(State or country) Maine

19 MAIDEN NAME OF MOTHER Susie Austin

20 BIRTHPLACE OF MOTHER (City) Montreal,
(State or country) Canada

21 Informant Jane A. Sullivan (sister)

(Address) 59 St. Andrew Rd. E. Boston

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

Paul C. Gossney
(Signature of Agent of Board of Health or other)

Health Officer March 1, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

Filed for burial permit
in Board of Health
or its Agent.

INSTRUCTIONS
FOR
CAL CERTIFICATE

NT OR TYPE
SE OR CAUSES
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,
ia, etc. It means
disease, or compli-
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ditions, if any,
ch gave rise to
ve cause (a),
ing the under-
ing cause last.

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

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.

FORM R-301

OUT - OF - TOWN

Suffolk
(County)EAST BOSTON
(City or Town)KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

01808

STANDARD
CERTIFICATE OF DEATH

Registered No.

filed for burial permit
h Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

No. COLUMBUS NURSING HOME St. (If death occurred in a hospital or institution,
(If deceased is a married, widowed or divorced woman, give also maiden name.) St. (If so specify WAR.)

PHYSICIAN — IMPORTANT

2 FULL NAME LENA E. PERLMUTTER (Was deceased a U. S. War Veteran, if so specify WAR.)

(a) Permanent Residence. No. 62 LOCUST St. WINTHROP (City or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....7 months.....days. In place of residence.....years.....46 months.....days.

NT OR TYPE
SE OR CAUSES
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),
the under-
lying cause last.

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 13 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 1960 to Feb 13 1965

I last saw her alive on Feb 13 1965, death is said to have occurred on the date stated above, at 10:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular occlusion 2 days
(b) Right Hemiplegia

(c) Generalized Arteriosclerosis 5 yrs.

OTHER
SIGNIFICANT
CONDITIONS

None

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

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS Date 2/14/1965

6 Chevra MISHNIAS WOBURN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 14 1965

7 NAME OF FUNERAL DIRECTOR T. D. F. Funeral Service Inc.

ADDRESS 151 Washington Ave Chelsea

Received and filed FEB 23 1965 19

Signature of Registrar

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of JOSEPH PERLMUTTER (Husband's name in full)

12 AGE 75 Years Months 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 AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) Riga Latvia (State or country)

17 NAME OF FATHER ISAAC GRUND

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

19 MAIDEN NAME OF MOTHER BAYLA

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

21 Informant HERBERT PERLMUTTER

(Address) 62 LOCUST St WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: E. Condon C 13828

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) Feb 14 1965

A TRUE COPY ATTEST:

AR 11 1965

Shore Drive
930-10AN

334
370

AT TRUE COPY ATTEST:

William J. Kane.



MAR 11 1905 AM

burial permit
d of Health
Agent.

CTIONS
OR
CERTIFICATE

OR TYPE
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dition given

OUT - OF - TOWN

Suffolk

(County)

West Roxbury

(City or Town)

PLACE OF DEATH

No. Veterans Administration Hospital

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

2 FULL NAME Edmund Gerard Barry

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

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, WW2
if so specify WAR)

(a) Permanent Residence. No. 6 Edgehill Road x Winthrop, Mass.

(City or town and State)

DOA

Length of stay: In place of death years months days. In place of residence 12 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 27 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
2/27/1965, to 2/27/1965
death is said to
have occurred on the date stated above, at 9:40 pm.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Insufficiency

(b) Due To Chronic Coronary Artery Disease yrs
Old anterolateral M I

(c) Due To Atherosclerosis

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

(Signature) Wm. D. MacPherson, M.D.

(Print or Type Name)

(Address) VAH W. Roxbury, Mass. date 19

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

DATE OF BURIAL March 3 1965

7 NAME OF FUNERAL DIRECTOR Maurice Kirby

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed MAR 3 1965 19

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 02455

50

(City or Town making this return)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word)
MARRIED single
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

12 AGE 63 Years 6 Months 18 Days If under 24 hours
Hours Minutes13 Usual Occupation Chapla in
(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 029-30-3608

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

17 NAME OF FATHER Edmund J. Barry

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

19 MAIDEN NAME OF MOTHER Bridget F. Sheehan

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

21 Informant VA Hospital Records

(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)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar



MAR 30 1885 AM

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

RECEIVED

FORM

To be filed
with B
or

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT
FOR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

52

Suffolk

(County)

Winthrop

(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No.

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

Mary Diamond (Handelman)

(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

11 Pearl Avenue

St. Winthrop, Mass.

(a) Permanent Residence. No. (Usual place of abode)

(City or town and State)

Length of stay: In place of death.....years.....months.....14 days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

MARCH 1, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

Nov. 1, 1941 to MARCH 1, 1965

I last saw her alive on Feb. 28, 1965, death is said to

have occurred on the date stated above, at 3:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular occlusion 2 wks

Due To Generalized Arteriosclerosis 3 yrs

Due To (b) (c)

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus 24 yrs. Prosthesis left Eye 25 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

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 3/1/1965

6 Beth Israel Cemetery, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 2, 1965

7 NAME OF FUNERAL DIRECTOR Torf Funeral Chapel

ADDRESS 151 Washington Ave., Chelsea

Received and filed March 1, 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widowed

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

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. none

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Joel Handelman

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

19 MAIDEN NAME OF MOTHER Esther Miller

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

21 Informant Esther Schultz
11 Pearl Avenue, Winthrop
(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)

Health Officer

(Official Designation)

March 1, 1965

(Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

iled for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CAL CERTIFICATE

NT OR TYPE
SE OR CAUSES
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,
ia, etc. It means
disease, 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
d to the terminal
e condition given

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.

MAR - 1 1935 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 53

Winthrop
(County)

Suffolk
(City or Town)

No. 180 Pauline Street

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

PHYSICIAN — IMPORTANT

2 FULL NAME Ester Lillian Hilton (Hatch)
(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. 180 Pauline Street
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 25 years 0 months 0 days. In place of residence 25 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 2 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
FEB 2, 1965, to MAR 2, 1965
I last saw her live on MAR 2, 1965, death is said to
have occurred on the date stated above, at 5:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY Occ.

Due To HYPERTENSIVE and ARTERIO

Due To SCLEROTIC HEART DIS.

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

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

(Print or Type Name)
MYRON N. KING M.D.

(Address) WILPLETON Date MAR 3 65

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

DATE OF BURIAL March 4 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Wintrop St. Winthrop.

Received and filed MAR 4 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Philip Raymond Hilton

(Husband's name in full)

12 66 10 19
AGE 66 Years 10 Months 19 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. 008-38-7949

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

17 NAME OF FATHER William Hatch

18 BIRTHPLACE OF FATHER (City) Wells
(State or country) Maine

19 MAIDEN NAME OF MOTHER Mary Jones

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

21 Informant William P. Hilton
(Address) 2451 S. State Rd. Ft. Florida

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

Paul C. Gaffney (R)

(Signature of Agent of Board of Health or other)

Director of Public Health

(Official Designation)

March 4 1965
(Date of Issue of Permit)

A TRUE COPY ATTEST:

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

MAR - 1955 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.

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

to 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),
ig the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

R 30 1965

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)

No. Beth Israel Hospital

Joseph Princi

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

(a) Permanent Residence. No. 22 Adams
(Usual place of abode)St. Winthrop, Mass.
(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 March 3 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
March 2, 19. 65, to March 3, 19. 65.
I last saw him live on March 3, 1965, death is said to
have occurred on the date stated above, at 6:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia

(b) Due To Prostate Obstruction &

(c) Due To Urinary Bladder Lithiasis

OTHER SIGNIFICANT CONDITIONS Bronchopneumonia
Left Ventricle Aneurysm

Was autopsy performed? Yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify(Signature) Alan M. Siegal, M. D.
(Print or Type Name)

(Address) 330 Brookline Ave Date Mar. 3, 19. 65

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 6th 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Poggiano

ADDRESS 147 WINTHROP ST WINTHROP

Received and filed March 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 02620

{(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
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of TERESA STRATI
(Give maiden name of wife in full)

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

12 AGE 83 Years 5 Months 1 Days If under 24 hours
Hours Minutes13 Usual Occupation TAILOR
(Kind of work done during most of working life)

14 Industry or Business CLOTHING MFG

15 Social Security No. 013-05-5572

16 BIRTHPLACE (City) ITALY
(State or country)

17 NAME OF FATHER MARK A PRINCI

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

19 MAIDEN NAME OF MOTHER MARIA MARTELLI

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

21 Informant MR. PETER PRINCI

(Address) 46 BARTLETT WAY WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:F. J. Draca C 22654
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) March 1965

TRUE COPY ATTEST:

11725288

William J. Kane.

City Registrar



MAR 30 1935 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 55

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 Frederick Eugene Slocum
(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 Underhill Street St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death years months 1 1/2 days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 3 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan., 1941, to March 3, 1965.
I last saw him alive on March 2, 1965, death is said to
have occurred on the date stated above, at 7:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Cecum 18 mos

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Ht. Disease 5 yrs.
DIABETES Mellitus. 4 yrs.

Was autopsy performed? Yes.

What test confirmed diagnosis Clinical and Pathological

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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 3/3/1965

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

DATE OF BURIAL March 5, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Mark

ADDRESS 174 Winthrop St. Winthrop,

Received and filed MAR 5 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of Elizabeth Campbell
(Give maiden name of wife in full)

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

12 AGE 74 Years 10 Months 2 Days If under 24 hours Hours Minutes

13 Usual Occupation proprietor bowling alley
(Kind of work done during most of working life)

14 Industry or Business self employed

15 Social Security No. 033-26-4046

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

17 NAME OF FATHER Israel Slocum

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

19 MAIDEN NAME OF MOTHER Marie MacIntosh

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

21 Informant Frederick E. Slocum, Jr.

(Address) 10 Underhill St. Winthrop

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

Paul C. Galtney
(Signature of Agent of Board of Health or other)

Director of Public Health March 5, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

iled for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CAL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
), (b) and (c)

does not mean
mode of dying,
as heart failure,
ia, etc. It means
sease, or compli-
which caused

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

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

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.

MAR - 5 1935 PM

M R-301A

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.

56

No. Mayflower Nursing Home

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

2 FULL NAME

39 Grovers Ave.
Louise P. Arend

(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. 240 Crescent Ave., Revere

St.

(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.

INSTRUCTIONS
FOR
CERTIFICATE

a giving
OF DEATH

not enter
than one
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
be cause or
of death on
certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 4, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2/24/1965, to 3/4/1965

I last saw her alive on 3/3/1965, death is said to have occurred on the date stated above, at 1:00 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia, viral.

INTERVAL
BETWEEN
ONSET AND
DEATH
1 Wk.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease, 24 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)

(Address)

Charles Liberman M. D.
WINTHROP, MASS. Date 3/4/19656 Place of Burial or Cremation Holy Cross Malden
DATE OF BURIAL March 8, 1965 197 NAME OF FUNERAL DIRECTOR Leslie W. Pike
ADDRESS 305 Beach St Revere

Received and filed MAR 8 1965 19

(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 7 Months 2 Days If under 24 hours Hours Minutes

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

14 Industry or Business None

15 Social Security No. None

16 BIRTHPLACE (City) South Boston
(State or country) Mass.

17 NAME OF FATHER Frederick Arend

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

19 MAIDEN NAME OF MOTHER Ann Fougere

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country) Canada21 Informant (Address) Records of Revere Old Age
City Hall Broadway - Revere

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

Paul C. Goffney (S)
(Signature of Agent of Board of Health or other)

Director of Public Health March 6, 1965
(Official Designation) (Date of Issue of Permit)

50M-1-58-921876

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., (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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No.

57

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
LOCAL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
a), (b) and (c)

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

ditions, if any,
h gave rise to
e cause (a),
ng the under-
t cause last.

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

33

1 PLACE OF DEATH
2 FULL NAME (SAUL) SOLOMON MIDDLE
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence. No. 18 BEACH RD. St. WINTHROP
(Usual place of abode) (City or town and State)
Length of stay: In place of death 20 years... months... days. In place of residence 20 years... months... days.

3 DATE OF DEATH MARCH 4, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
I last saw him alive on 19... death is said to have occurred on the date stated above, at 7:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Death presumably due
(b) Due to natural causes, probably
(c) acute coronary occlusion
on basis of history

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

(Signature) Charles Liberman, M.D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 3/4/1965

6 SHARON MEM. PARK, SHARON
Place of Burial or Cremation (City or Town)
DATE OF BURIAL MARCH 5, 1965

7 NAME OF FUNERAL DIRECTOR BENJAMIN BIRNBACH
ADDRESS 1668 BEACON ST. BROOKLINE
Received and filed MAR 5 1965

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED
11 If married, widowed, or divorced HUSBAND of ALICE MIDDLE (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)
12 AGE 65 - 5-30-1904 If under 24 hours
13 Usual Occupation SALESMAN (Kind of work done during most of working life)
14 Industry or Business CANDY
15 Social Security No. 098-09-9329
16 BIRTHPLACE (City) (State or country) LONDON, ENGLAND

PARENTS
17 NAME OF FATHER ISAAC MIDDLE
18 BIRTHPLACE OF FATHER (City) (State or country) POLAND
19 MAIDEN NAME OF MOTHER ESTHER (UNKNOWN)
20 BIRTHPLACE OF MOTHER (City) (State or country) POLAND

21 Informant MRS. SAUL MIDDLE (Address) 18 BEACH RD. 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:

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.

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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.

MAR - 5 1935 PM

FORM R-301

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
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, (b) and (c)

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

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

ditions contrib-
death but not
to the terminal
condition given

BB

R 30 1965

Director

use only

ACK Ink.

OUT - OF - TOWN

The Commonwealth of Massachusetts

SUFFOLK

(County)

BOSTON

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

58

02626

Registered No.

STANDARD CERTIFICATE OF DEATH

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 Bessie M. Glover (Davis)
(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) Permanent Residence. No. 70 Bowdoin St. Winthrop, Massachusetts
(Usual place of abode) (City or town and State)

Length of stay: In place of death 4 years 4 months 4 days. In place of residence 81 years 4 months 4 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 5, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That attended deceased from March 1, 1965, to March 5, 1965
we last saw her alive on March 5, 1965, death is said to have occurred on the date stated above, at 12:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

MYOCARDIAL INFARCTION

(a) Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

OSTEO POROSIS

Was autopsy performed? YESWhat test confirmed diagnosis? AUTOPSY

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

(Signature) Charles L. Glover, M.D., M. D.

Charles L. Glover, M.D.
(Print or Type Name)

(Address) Ass'n. Dir., Mass. Gen'l. Hosp. Date March 5, 1965

6 Woodlawn Crematory Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 8, 19657 NAME OF FUNERAL DIRECTOR Howard S ReynoldsADDRESS Winthrop Mass.Received and filed March 6, 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Tracy Glover
(Give maiden name of wife in full)

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

12 AGE 87 Years 8 Months 26 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) Marshfield
(State or country) Mass.

17 NAME OF FATHER James W Davis

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

19 MAIDEN NAME OF MOTHER Mae Bell

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)

21 Informant Leland Glover

(Address) 34 Congress St. Amesbury

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)

Medical Examiner to countersign

RUE COPY ATTEST:

William J. Kane.

City Registrar

MAR 3 10 55 AM

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
l, (b) and (c)

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

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ng the under-
cause last.

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

B-B

The Commonwealth of Massachusetts



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop, Mass

(City or Town)

Winthrop Community Hospital

No.

STANDARD

CERTIFICATE OF DEATH

Registered No.

59

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

PHYSICIAN — IMPORTANT

2 FULL NAME **Eva Sandler (Glickson)**
(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) Permanent Residence. No.
(Usual place of abode)

6 Wave Way Ave

Winthrop, Mass.

St.

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **MARCH 5 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 1963 to **MARCH 5 1965**

I last saw him alive on **MARCH 5 1965**, death is said to
have occurred on the date stated above, at **2:20 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebral Hemorrhage** 39 yrs

(b) **Cerebral Arteriosclerosis** 59 yrs

(c) **Hypertension** 39 yrs

OTHER SIGNIFICANT CONDITIONS **Parkinson's Syndrome** 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

(Signature) **Charles Liberman M.D.**
CHARLES LIBERMAN

(Address) **WINTHROP, MASS 3151** Date **3/5/1965**

6 **Tifereth Israel & Rorer - Everett**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **MARCH 7 1965**

7 NAME OF FUNERAL DIRECTOR **TORF Funeral Service**

ADDRESS **151 Washington Ave Chelsea**

Received and filed **MAR 8 1965** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **F** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED
WIDOWED **WIDOWED**
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of **MORRIS SANDLER**
(Husband's name in full)

12 **29** AGE **29** 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) **Russia**
(State or country)

17 NAME OF FATHER **ELI GLICKSON**

18 BIRTHPLACE OF FATHER (City) **Russia**
(State or country)

19 MAIDEN NAME OF MOTHER **STARRA C.B.**

20 BIRTHPLACE OF MOTHER (City) **Russia**
(State or country)

21 Informant **Celia Dollin**
(Address) **6 Wave Way Winthrop**

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

Paul C. Goffney
(Signature of Agent of Board of Health or other)
Director of Public Health - March 6 1965
(Official Designation) (Date of Issue of Permit)

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 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.

for burial permit
ward of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

oes not mean
e of dying,
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se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
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itions contrib-
death but not
the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 18 TEWKSBURY ST

STANDARD
CERTIFICATE OF DEATH

Registered No.

60

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

(a) Permanent Residence. No. 18 TEWKSBURY

St. WINTHROP

(City or town and State)

Length of stay: In place of death 23 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 6 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan. 50 to MARCH 6 1965
I last saw him live on MARCH 6, 1965, death is said to
have occurred on the date stated above, at 4:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 1 day
(b) Arteriosclerotic Heart Disease 4 yrs.
(c) Disease

OTHER SIGNIFICANT CONDITIONS Left Hemiparesis 2 yrs.
Diabetes Mellitus 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

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. 3/6/1965

6 HAND IN HAND WEST ROXBURY
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 7 1965

7 NAME OF FUNERAL DIRECTOR SOLOMON FUNERAL HOME INC

ADDRESS 420 HARVARD ST BROOKLINE

Received and filed MAR 8 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED MARRIED
UNKNOWN

11 If married, widowed, or divorced ESTHER COHEN
HUSBAND of (Give maiden name of wife in full)

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

12 AGE 57 Years Months Days If under 24 hours
Hours Minutes

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

14 Industry or Business DRUGSTORE

15 Social Security No. 021-09-1670

16 BIRTHPLACE (City) LYNN MASS
(State or country)

17 NAME OF FATHER ISADORE ZIEFF
18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)
19 MAIDEN NAME OF MOTHER IDA CABIT
20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

21 Informant MRS ESTHER ZIEFF (WIFE)
18 TEWKSBURY ST WINTHROP
(Address)

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

Rae C. Gaffney
(Signature of Agent of Board of Health or other)
Director of Public Health March 6, 1965
(Official Designation) (Date of Issue of Permit)

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.

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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

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No.

61

No. Bayview Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Frank V. J. Cochran

(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

566 Shirley

Winthrop

(a) Residence, No. (Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death, 1 years, months, days. In place of residence, 60 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 8 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Mar 30 55 to March 8 1965

I last saw him live on MAR 8 1965, death is said to have occurred on the date stated above, at 11:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACT 6 days

Due To (b) Arterio-sclerotic Heart Disease

Due To (c) general arterio-sclerosis 3 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

(Signature) Myron H. King, M. D.

(Address) Myron H. King, 100 Pleasant St., Winthrop, Mass.

Date 3/10 1965

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 11, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 10 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed or divorced HUSBAND of Katherine Thomas (Give maiden name of wife in full)

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

12 AGE 80 10 4 If under 24 hours Hours Minutes

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

14 Industry or Business, Narrow Gauge Rail Road

15 Social Security No. 023-10-6856

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

17 NAME OF FATHER John Cochran

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

19 MAIDEN NAME OF MOTHER Margaret Linehan

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

21 Informant Katherine Cochran 566 Shirley St., Winthrop (Address)

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

Paul C. Gagnier (31) (Signature of Agent of Board of Health or other) Director of Public Health Mar 10 1965 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

ed for burial permit
ard of Health
Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

NT OR TYPE
SE OR CAUSES
OF DEATH

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

s does not mean
mode of dying,
as heart failure,
ia, etc. It means
disease, or compli-
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to death but not
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3P

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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(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.

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

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, (b) and (c)

does not mean
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cause (a),
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to death but not
to the terminal
condition given

B

I

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 191 Woodside Ave.

2 FULL NAME

Nina M. Lamb (MacFarland)

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

(a) Permanent Residence. No. 191 Woodside Ave.

St. Winthrop

(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 March 9 1965
(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 12:15 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

(b) Due To natural causes.

(c) Due To Winthrop Board of Health

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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) Winthrop, Mass. Date 3/10/1965

6 Woodlawn Cemetery Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 12, 1965

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St. E. Boston

Received and filed MAR 10 1965

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No.

62

(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 WARI

No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William Lamb
(Husband's name in full)12 AGE 82 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 At Home

15 Social Security No None

16 BIRTHPLACE (City) Waldoboro, Maine
(State or country)

17 NAME OF FATHER Joseph C.B.L. MacFarland

18 BIRTHPLACE OF FATHER (City) C.B.L.
(State or country)

19 MAIDEN NAME OF MOTHER Sarah C.B.L. BRENNER

20 BIRTHPLACE OF MOTHER (City) C.B.L.
(State or country)

21 Informant Mrs. Elizabeth Vazquez

(Address) 191 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:

Paul C. Gaffney, Jr.

(Signature of Agent of Board of Health or other)

Director of Public Health March 1965

(Official Designation)

(Date of Issue of Permit)

(Registrar)

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. For children not gainfully employed, report as at school or at home. For a woman whose only occupation is that of home housework, write housewife. For a person engaged in domestic service, give wages, however, designate occupation by the appropriate term, as housekeeper—private family, cook—hotel, etc. For a person whose occupation is unknown, write none.

MAR 1 1915

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No.

63

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

(a) Permanent Residence. No. 28 FLOYD
(Usual place of abode)

St. WINTHROP
(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 10, 1965
(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 11:54 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To natural causes, probably

(b) acute coronary occlusion

(c) on basis of history.

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?

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP Date 3/11/1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 12, 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP

Received and filed MAR 11 1965 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

MALE WHITE MARRIED
WIDOWED
DIVORCED MARRIED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of CAROLINE H. HAYWARD
(Give maiden name of wife in full)

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

12 25 Years.....Months.....Days If under 24 hours
AGE.....Hours.....Minutes

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

14 Industry or Business INSURANCE

15 Social Security No. 029-26-9245 A

16 BIRTHPLACE (City) PARSON
(State or country) NY

17 NAME OF FATHER UNKNOWN

18 BIRTHPLACE OF FATHER (City).....
(State or country) NY

19 MAIDEN NAME OF MOTHER UNKNOWN

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

21 Informant MRS CAROLINE H. GRAY
(Address) 28 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:

Paul C. Gaffney, M.D.
(Signature of Agent of Board of Health or other)

March 11 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
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use for each
i), (b) and (c)

does not mean
mode of dying,
as heart failure,
ia, etc. It means
sease, or compli-
which caused

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

nditions contrib-
o death but not
to the terminal
condition given

B.

63-936348

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

RULES OF PRACTICE

MAR 1 1 1935 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.

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

NT OR TYPE
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F DEATH

o not enter
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cause last.

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o death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop, Mass.
(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 64

No. 41 Belcher Street,

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

PHYSICIAN — IMPORTANT

2 FULL NAME William Rosferd Kelsey
(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. 41 Belcher Street
(Usual place of abode)

st. Winthrop, Mass.
(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 March 13, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from
June 2, 1962, to March 13, 1965.
I last saw him alive on March 13, 1965, death is said to
have occurred on the date stated above, at 4:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY OCCLUSION

Due To ARTERIO-SCLEROTIC HEART
(b) AND HYPERTENSIVE HEART 3 YRS
Due To HEART BLOCK COMPLETE &
(c) GENERAL ARTERIO-SCLEROSIS

OTHER SIGNIFICANT CONDITIONS CHRONIC BRONCHITIS 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

(Signature) Myron N. King, M. D.
(Print or Type Name)

(Address) 222 Pleasant St. Winthrop, Mass.
Date 3/15/65

6 New Harbor Cem. New Harbor,
Place of Burial or Cremation (City or Town) Maine

DATE OF BURIAL March 16, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed MAR 15 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Emma Helen (Davis) Kelsey
(Give maiden name of wife in full)

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

12 AGE 81 Years 3 Months 23 Days If under 24 hours
Hours Minutes

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

14 Industry or Business Marine Engineering

15 Social Security No. 020-14-7403

16 BIRTHPLACE (City) Bristol, Maine
(State or country)

17 NAME OF FATHER Rosferd Cyrus Kelsey

18 BIRTHPLACE OF FATHER (City) Bristol, Maine
(State or country)

19 MAIDEN NAME OF MOTHER Nellie Richards

20 BIRTHPLACE OF MOTHER (City) Bristol, Maine
(State or country)

21 Informant Miss Helen M. Kelsey

(Address) 41 Belcher 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:

Paul C. Goffinet (Signature of Agent of Board of Health or other)
Director of Public Health March 15, 1965
(Official Designation) (Date of Issue of Permit)

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.

RECEIVED



MAR 15 1935 PM

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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cause last.

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o death but not
to the terminal
condition given

B

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop, Mass

(City or Town)

Winthrop Community Hospital

No.

STANDARD

CERTIFICATE OF DEATH

Registered No.

65

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

PHYSICIAN — IMPORTANT

John McNaught

2 FULL 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)

16 Wilshire Street

Winthrop, Mass.

(a) Permanent Residence. No.
(Usual place of abode)

St. (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 MARCH 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
11/1, 1961 to MARCH 16, 1965
I last saw him alive on MARCH 16, 1965, death is said to
have occurred on the date stated above, at 10:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF LUNG

(b) SECONDARY ANEMIA - SEVERE

(c) ARTERIO-SCLEROTIC HEART DIS

OTHER SIGNIFICANT CONDITIONS
CHAGRENOUS H. LEFT TEL

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

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

(Address) 220 Pleasant St. Winthrop, Mass. Date. March 16, 1965

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

DATE OF BURIAL March 19 65

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed MAR 18 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Alice M Collins
(Give maiden name of wife in full)

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

12 AGE 81 Years 10 Months 10 Days If under 24 hours
Hours.....Minutes

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

14 Industry or Business Bank

15 Social Security No. None

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

17 NAME OF FATHER John McNaught

18 BIRTHPLACE OF FATHER (City) Eastport
(State or country) Maine

19 MAIDEN NAME OF MOTHER Annie Armstrong

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

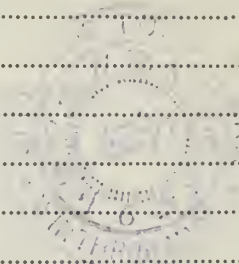
21 Informant Carolyn McNaught

(Address) 16 Wilshire 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:

Paul C. Gaffney (B)
(Signature of Agent of Board of Health or other)
Director Public Health March 18 1965
(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.....



MAR 1 8 1935 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.

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
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ode of dying,
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to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

66

1 PLACE OF DEATH
SUFFOLK
(County)
WINTHROP
(City or Town)

No. BAYVIEW NURSING HOME STURGIS

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

PHYSICIAN — IMPORTANT

2 FULL NAME ISABELLA A RACICH (KELLY)
(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) Permanent Residence. No. 275 COURT RD
(Usual place of abode)

St. WINTHROP
(City or town and State)

Length of stay: In place of death 1 years months days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
DEC 27 1957 to MAR 16 1965

I last saw h. live on MAR 15 65, death is said to
have occurred on the date stated above, at 7:40 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

INTERVAL
BETWEEN
ONSET AND
DEATH

2 YRS

Due To ADENOCARCINOMA OF BREAST 2 1/2 YRS
(b)

Due To GENERAL ARTERIOSCLEROSIS 5 YRS
(c)

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 10 YRS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL + PATHOLOGICAL

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

(Signature) MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST. WINTHROP MASS Date MAR 18 65

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 19 1965

7 NAME OF FUNERAL DIRECTOR MAURILE W. KIRBY

ADDRESS WINTHROP

Received and filed MAR 19 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

FEMALE WHITE MARRIED
WIDOWED
DIVORCED
UNKNOWN WIDOWED

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

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

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

14 Industry or Business HOME

15 Social Security No. 010-30-9364

16 BIRTHPLACE (City) ROXBURY
(State or country) MASS

17 NAME OF FATHER TIMOTHY KELLY

18 BIRTHPLACE OF FATHER (City) ROXBURY
(State or country) MASS

19 MAIDEN NAME OF MOTHER ANNIE BURME

20 BIRTHPLACE OF MOTHER (City) ROXBURY
(State or country) MASS

21 Informant MRS MARGARET REESE

(Address) 275 COURT RD WINTHROP

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

Paul C. Goffney (B)

(Signature of Agent of Board of Health or other)

Director of Public Health March 18, 1965

(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

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.

67

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

House

No. Cliff Nursing Home

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

2 FULL NAME Louis Browning

(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. 36 Grand View Avenue

(Usual place of abode)

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

Length of stay: In place of death 12 years 12 months 12 days. In place of residence 35 years 12 months 12 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 20 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
you 19 25 to March 20 19 65
I last saw him alive on 2-15 19 65 death is said to

have occurred on the date stated above, at 7:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) congestive heart failure

INTERVAL
BETWEEN
ONSET AND
DEATH

5 yrs

Due To Senility

(b)

yrs.

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS Coronary artery heart
disease

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) H. Greenfield, M. D.

(Address) 447 Winthrop St. Date 3-20 19 65

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 23, 1965 19 65

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed MAR 22 1965 19 65

(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 Pearl Lydia Farmer
(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 18 Days
If under 24 hours
Hours Minutes

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

14 Industry or Business: self employed

15 Social Security No. 001-24-5140

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

17 NAME OF FATHER Napoleon Browning

18 BIRTHPLACE OF FATHER (City) Livingston
(State or country) New York

19 MAIDEN NAME OF MOTHER Annie Foster

20 BIRTHPLACE OF MOTHER (City) Detroit
(State or country) Michigan

21 Informant Mrs. Louis Browning
(Address) 36 Grand View Avenue

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

Paul C. Gaffney
(Signature of Agent of Board of Health or other)

Director of Public Health March 22, 1965
(Official Designation) (Date of Issue of Permit)

J.B.V.

M R-301A

INSTRUCTIONS
FOR
CERTIFICATE

1 giving
OF DEATH
not enter
than one
for each
(b) and (c)

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

ians, 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
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 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., (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.

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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.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
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),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 68

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

CHARLES PETER LOWELL

(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.

249 PLEASANT ST

St.

WINTHROP

(Usual place of abode)

(City or town and State)

Length of stay: In place of death. 1 years 3 months 4 days. In place of residence. 3 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

March 23

1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased, from

June 1962, to March 23, 1965

I last saw him alive on March 19, 1965, death is said to

have occurred on the date stated above, at 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

Due To

(b) arteriosclerosis

Due To

(c)

INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
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

(Signature)

Joseph G. Galtrey, M. D.

(Print or Type Name)

(Address) 19 Washington St Date 3-26-65

6 MT PLEASANT

Place of Burial or Cremation

ARLINGTON

(City or Town)

DATE OF BURIAL

MARCH 27

1965

7 NAME OF
FUNERAL DIRECTOR

MAURIE W. KIRBY

ADDRESS

WINTHROP

Received and filed

MAR 26 1965

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MALE

WHITE

MARRIED

WIDOWED

DIVORCED

UNKNOWN

WIDOWED

11 If married, widowed, or divorced

HUSBAND of ELIZABETH DRYER

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

77 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation

CABINET WORKER

(Kind of work done during most of working life)

14 Industry

or Business BUILDING

15 Social Security No.

022-03-0531

16 BIRTHPLACE (City)

NEWTON

(State or country)

MASS

17 NAME OF

FATHER

CHARLES W. LOWELL

18 BIRTHPLACE OF

FATHER (City)

CAMBRIDGE

(State or country)

MAINE

19 MAIDEN NAME

OF MOTHER

JENNIE TOOLEY

20 BIRTHPLACE OF

MOTHER (City)

NEWTON

(State or country)

MASS

21 Informant

MRS. GRACE MURPHY

(Address)

249 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:

Paul C. Galtrey

(Signature of Agent of Board of Health or other)

Director of Public Health

March 26, 1965

(Official Designation)

(Date of Issue of Permit)

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.

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
(a), (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-
o death but not
e to the terminal
condition given

Suffolk
Winthrop

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Alice C (Andrews) Nielsen

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

42 Plummer Ave

(a) Permanent Residence. No.
(Usual place of abode)

St.

(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 MAR 27 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12/21, 1963, to MAR 27, 1965

I last saw him alive on MAR 22, 1965, death is said to have occurred on the date stated above, at 10:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION 12 HRS

Due To ARTERIO SCLEROTIC HEART DYS 2 YRS

(b) (c) MILD GENERAL ARTERIO SCLEROSIS ALMOST TOTAL TO CATARACTS 6 YRS

OTHER SIGNIFICANT CONDITIONS NONE - BLINDNESS DUE TO CATARACTS

Was autopsy performed? No

What test confirmed diagnosis? L.R.G.

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

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

MYRON N. KING M.D.

(Print or Type Name)

(Address) 222 PLEASANT ST. Date 3/27/65

Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 30 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

Winthrop, Mass

ADDRESS

Received and filed 3-30-1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

69

(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 Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Widowed DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of

(or) WIFE of Albert P Nielsen (Give maiden name of wife in full)

(Husband's name in full)

12 AGE 83 Years 6 Months 28 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) Lynn (State or country) Mass

17 NAME OF FATHER Charles Andrews

18 BIRTHPLACE OF FATHER (City) Unable to obtain (State or country)

19 MAIDEN NAME OF MOTHER Anna Singleton

20 BIRTHPLACE OF MOTHER (City) Unable to obtain (State or country)

21 Informant Ruth Nielsen

(Address) 42 Plummer 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:

Paul C Goffney Jr

(Signature of Agent of Board of Health or other)

Director of Public Health

March 30 1965

(Official Designation)

(Date of Issue of Permit)

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.

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RECORDED

MAR 30 1935

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
), (b) and (c)

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

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

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

P.

Suffolk

(County)

Winthrop

(City or Town)

No. 77 Bartlett Rd.

John G Baker

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

(a) Permanent Residence. No. 162 Pleasant Street
(Usual place of abode)

Length of stay: In place of death.....years 3.....months.....days. In place of residence.....60.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 30 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1965, to March 30, 1965.
I last saw him alive on March 29, 1965, death is said to have occurred on the date stated above, at 3:35 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Broncho pneumonia (terminal) 3 days
(b) Carcinoma of Lungs 2 mos
(c) Carcinoma of Stomach Months

OTHER SIGNIFICANT CONDITIONS arteriosclerosis generalized 4 yrs

Was autopsy performed? No
What test confirmed diagnosis? h5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) Joseph Greffie, M. D.
(Print or Type Name) Joseph Greffie
(Address) 194 Washington St. Winthrop, Mass. Date March 31, 19656 South Dennis South Dennis
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 1, 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed APR - 1 1965
John A. Clark (Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 70

(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 Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced HUSBAND of Sadie Thacher
(Give maiden name of wife in full)

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

12 87 5 6 If under 24 hours
AGE Years Months Days Hours Minutes13 Usual Occupation Owner
(Kind of work done during most of working life)

14 Industry or Business Furniture Co.

15 Social Security No. 022-07 9870

16 BIRTHPLACE (City) West Dennis
(State or country) Mass

17 NAME OF FATHER Browning Baker

18 BIRTHPLACE OF FATHER (City) West Dennis
(State or country) Mass

19 MAIDEN NAME OF MOTHER Abbie Baxter

20 BIRTHPLACE OF MOTHER (City) West Dennis
(State or country) Mass21 Informant Sadie Baker
(Address) 162 Pleasant 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) Director of Public Health 4/1/65
(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.....

APR - 1 1955 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.

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The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

71

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 161

No. Soldiers' Home Hospital

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

2 FULL NAME David J. Hartigan

(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. 641 Pleasant

(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months 17 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

Mar. 12, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Feb. 24, 1965, to Mar. 12, 1965

I last saw him alive on Mar. 12, 1965, death is said to

have occurred on the date stated above, at 2 p. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart

(b) Due To disease with severe

(c) Due To coronary sclerosis

Extensive septal infarct

INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
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

(Signature) Leo R. Sullivan

M. D.

(Address) Soldiers' Home

Date 3/12/65

6 Holy Cross, Malden, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Mar. 15, 1965

7 NAME OF FUNERAL DIRECTOR Killion Fun. Home

ADDRESS 1 Sprague St., Revere, Mass.

Received and filed APR 26 1965

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Male

White

Married

11 If married, widowed, or divorced

HUSBAND of Nora Clancy
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

12

AGE 75 Years 0 Months 26 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Police Officer (retired)
(Kind of work done during most of working life)

14 Industry

or Business: City of Revere

15 Social Security No. not known

16 BIRTHPLACE (City)

(State or country) So. Framingham, Mass.

17 NAME OF

FATHER

David P. Hartigan

18 BIRTHPLACE OF

FATHER (City)

(State or country) Canada

19 MAIDEN NAME

OF MOTHER

Catherine Costello

20 BIRTHPLACE OF

MOTHER (City)

(State or country) Ireland

21 Informant Hospital Records

(Address) Soldiers' Home, Chelsea, Mass.

A TRUE COPY

ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED Mar. 12, 1965

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.)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE..... 11/9/17
DATE OF DISCHARGE..... 5/29/19
RANK, RATING..... Sgt. Det. Sup. Co., 1st army Hdqtrs. Reg.
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER..... not known

RULES OF PRACTICE

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

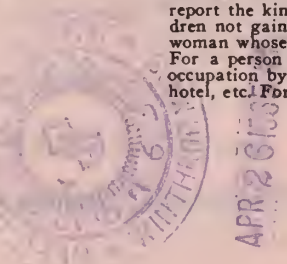
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



FORM R-302

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 168

No. Soldiers' Home Hospital

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

2 FULL NAME Jacob F. Mulsman

(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. 53 Trident Ave.

(Usual place of abode)

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 0 years 0 months 19 days. In place of residence 0 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

Mar. 16, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Feb. 27, 1956, to Mar. 16, 1965

I last saw him alive on Mar. 16, 1965 death is said to

have occurred on the date stated above, at 5:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH

(a) Arteriosclerotic heart disease

(b) Cerebral vascular accident,

(c) status epilepticus; chronic brain syndrome

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

(Signature) D.C. Desai, M. D.

(Address) Soldiers' Home Date 3/17/65

6 American Friendship, West Roxbury, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Mar. 18, 1965

7 NAME OF FUNERAL DIRECTOR Torf Hum. Serv.

ADDRESS 151 Washington Ave., Chelsea

Received and filed APR 26 1965

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Married

11 If married, widowed, or divorced

HUSBAND of Lillian Weiner (Give maiden name of wife in full)

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

12

AGE 71 Years 5 Months 16 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Factory Worker

(Kind of work done during most of working life)

14 Industry

or Business: not known

15 Social Security No. 021-01-8139

16 BIRTHPLACE (City)

(State or country)

Haverhill, Mass.

17 NAME OF

FATHER

Lewis Mulsman

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Russia

19 MAIDEN NAME

OF MOTHER

Jennie Shapiro

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Russia

21 Informant Hospital Records

(Address) Soldiers' Home, Chelsea, Mass.

A TRUE COPY

ATTEST: Joseph A. Tyrrell (Registrar of City or Town where death occurred)

DATE FILED Mar. 17, 1965

4.B ✓

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.)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE..... July 2, 1917
DATE OF DISCHARGE..... Feb. 17, 1919
RANK, RATING..... Seaman 2nd class
ORGANIZATION AND OUTFIT..... U.S. Navy
SERVICE NUMBER..... 144-21-42

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.

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

GRAFTON

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH

WORCESTER

(County)

GRAFTON

(City or Town)

No. Grafton State Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Ida L. Willett (Lambkin)

(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) Permanent Residence. No. 10 Seaview Ave. St. Winthrop, Mass.
(Usual place of abode) (City or town and State)Length of stay: In place of death 11 years 4 months 4 days. In place of residence Not Learned years Not Learned months Not Learned days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 24, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
March 9, 1965, to March 24, 1965.I last saw her alive on March 24, 1965, death is said to
have occurred on the date stated above, at 10:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma Hepatic Flexure 1 Yr.(b) #153.1

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NO
What test confirmed diagnosis? Expl. Laparotomy5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify(Signature) J. V. Mangubat, M.D., M. D.(Address) N. Grafton, Mass. Date Mar. 24, 656 Brookdale Cem., Dedham, Mass.
Place of Burial or Cremation (City or Town)DATE OF BURIAL March 29, 19657 NAME OF FUNERAL DIRECTOR Eaton Funeral HomeADDRESS Needham, Mass.Received and filed APR 12 1965 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
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of
(Give maiden name of wife in full)(or) WIFE of Ida L. Willett
(Husband's name in full)12 AGE 78 Years 6 Months 22 Days
If under 24 hours
.....Hours..... Minutes13 Usual Occupation: Not Learned
(Kind of work done during most of working life)14 Industry or Business: Not Learned15 Social Security No. --
16 BIRTHPLACE (City) New York
(State or country) New York17 NAME OF FATHER Charles Lambkin18 BIRTHPLACE OF FATHER (City) Canada
(State or country)19 MAIDEN NAME OF MOTHER Catherine J. May20 BIRTHPLACE OF MOTHER (City) New York
(State or country) New York21 Informant Grafton State Hosp. Records(Address) North Grafton, Mass.

A TRUE COPY

ATTEST: Raymond P. Anderson
(Registrar of City or Town where death occurred)DATE FILED March 29, 1965WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -
THIS IS A PERMANENT RECORDCopies 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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



APR 12 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Bedford

(City or Town making this return)

Middlesex

(County)

Bedford

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 74

No. V. A. Hospital, Bedford, Massachusetts St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Levon MOORADIAN { (Was deceased a U. S. War Veteran, if so specify WAR) W-1
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 7 Locust St. Wintthrop, Massachusetts
(City or town and State)

Length of stay: In place of death 1 years 8 months 20 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 1 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 11 1963 to April 1 1965

I last saw him alive on April 1 1965 death is said to have occurred on the date stated above, at 1:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Myocardial infarction associated with cerebral arteriosclerosis 7 yrs
2 yrs

Was autopsy performed? NoWhat test confirmed diagnosis? Clinical

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

(Signature) SAVINO DISCREGARIO M. D.

(Address) VAN, Bedford, Mass. Date April 1 1965

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

DATE OF BURIAL April 3 1965

7 NAME OF FUNERAL DIRECTOR Aras Bedrossian Fun. Home

ADDRESS Mt. Auburn St., Watertown, Mass.

Received and filed April 9, 1965

(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
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced Agnes Nahabedian
HUSBAND of (Give maiden name of wife in full)

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

12 AGE 72 10 16 Days If under 24 hours
Years Months Days Hours Minutes

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

14 Industry or Business:

15 Social Security No. 014 22 8831

16 BIRTHPLACE (City) Armenia, Turkey
(State or country)

17 NAME OF FATHER Mitchell Mooradian

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

19 MAIDEN NAME OF MOTHER Altoon Sarkesian

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

21 Informant V. A. Hospital Records
(Address) Bedford, Massachusetts

A TRUE COPY Donald Pfeiffer
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED APR - 8 1965

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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE June 21, 1918

DATE OF DISCHARGE 4 December 9, 1918

RANK, RATING Private First Class

ORGANIZATION AND OUTFIT U. S. Army

SERVICE NUMBER 3120257



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

75

((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 Rose (Augello) Caruana

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

(a) Permanent Residence. No. 20 Bellevue Ave.
(Usual place of abode)

St. Winthrop Mass

(City or town and State)

Length of stay: In place of death.....years.....months.....2 days. In place of residence.....5 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 2 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 6, 1965, to April 2, 1965

I last saw her alive on April 1, 1965, death is said to
have occurred on the date stated above, at 8:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO-SCLEROTIC HEART DISEASE

Due To (b) AND NEPHROSCLEROSIS

Due To (c) E CONGESTIVE HEART FAILURE
SEVERAL

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

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

MYRON N. KING M.D.

(Address) WINTHROP ST. Date April 2, 1965

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 5, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

147 Winthrop St., Winthrop

ADDRESS

Received and filed APR - 5 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Alfonso Caruana

(Husband's name in full)

12 AGE 88 years 1 Months 21 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 Francesco Augello

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

19 MAIDEN NAME OF MOTHER Vincenza Gagliano-Pisa

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

21 Informant Alfonso Caruana

(Address) 20 Bellevue Ave., Winthrop

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

Paul C. Gagnier

(Signature of Agent of Board of Health or other)

Director of Public Health April 5-1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

ed for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

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

does not mean
ode of dying,
s heart failure,
a, etc. It means
e, or compli-
on which caused

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

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

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:

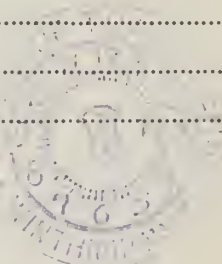
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



APR - 5 1965 PM

ed for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
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

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

ditions contrib-
death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

Winthrop Community Hospital

2 FULL NAME Mary (Forrest) Babcock
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 180 Crescent Ave St. Revere
(Usual place of abode)

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, N O
if so specify WAR)

Length of stay: In place of death.....years.....months.....3 days. In place of residence.....39 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 3 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Feb. 28, 1964, to April 3, 1965.I last saw her alive on April 3, 1965, death is said to
have occurred on the date stated above, at 1:50p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized carcinomatosis

(b) Due To Adenocarcinoma of the
rectum

(c) Due To

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? no
What test confirmed diagnosis? clinical & lab5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traustein Jr., M.D.

(Print or Type Name)
M. Traustein Jr., M.D.(Address) 73 Bartlett Rd., Date 4-3 1965
Winthrop, Mass.6 Pine Grove Lynn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 6, 1965

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave., Revere

Received and filed APR 5 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

76

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Lester R. Babcock
(Husband's name in full)12 AGE 67 Years 4 Months 12 Days If under 24 hours
Hours Minutes13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business None H H

15 Social Security No.

16 BIRTHPLACE (City) Portland Maine
(State or country)

17 NAME OF FATHER Thomas Forrest

18 BIRTHPLACE OF FATHER (City) Memphis
(State or country) Tenn.

19 MAIDEN NAME OF MOTHER Margaret Malloy

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Lester R. Babcock
(Address) 180 Crescent Avenue, 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)
Director of Public Health April 5, 1965
(Official Designation) (Date of Issue of Permit)

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:

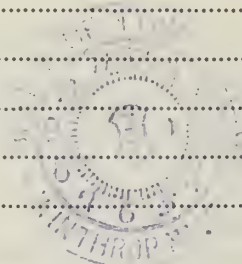
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(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 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.



APR - 5 1965 PM

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

TYPE OR TYPE
OR CAUSES
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-
cation which caused

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

conditions contrib-
ing to death but not
contributing to the terminal
condition given

B.B.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

77

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 CERTRUDE HOUGH (FITZGERALD)

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

(Was deceased a NONE
U. S. War Veteran,
if so specify WAR)(a) Permanent Residence, No. 23 SIREN STREET
(Usual place of abode)

St. WINTHROP

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 4, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

JULY 50, 1950, to APRIL 4, 1965

I last saw him alive on April 4, 1965 death is said to

have occurred on the date stated above, at 4:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion 2 days

(b) Due To Hypertensive - Coronary 7 yrs

(c) Artery Heart Disease 5 yrs

OTHER SIGNIFICANT CONDITIONS Status Mid THIGH Amputation 2 1/2 yrs

RIGHT

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

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

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 4/4/1965

6 Forest Hills Cemetery Boston 30

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 7, 1965

7 NAME OF FUNERAL DIRECTOR Thomas F. Brady

ADDRESS 40 Tower St. Boston 30, Mass.

Received and filed APR - 5 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

12 AGE 69 Years 10 Months 1 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 Own Home

15 Social Security No. 030 20 8867

16 BIRTHPLACE (City or country) Norwood Mass.

17 NAME OF FATHER Thomas Fitzgerald

18 BIRTHPLACE OF FATHER (City or country) Cannot Be Learned

19 MAIDEN NAME OF MOTHER Mary E. Cahill

20 BIRTHPLACE OF MOTHER (City or country) Ireland

21 Informant Mrs. Marion Harson

(Address) 150 Grand View 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)

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:

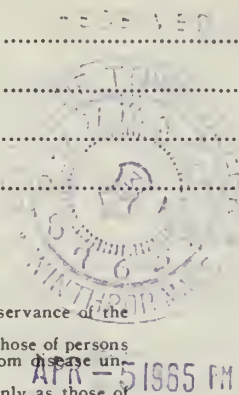
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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

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.



ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

CAUSE OR TYPE
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-
cation which caused

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

conditions contrib-
uted to death but not
to the terminal
condition given

1.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

78

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 104 JOHNSON AVE

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

2 FULL NAME. NORA L BRENNAN (GRADY)

(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) Permanent Residence. No. 104 JOHNSON AVE

(Usual place of abode)

St. WINTHROP

(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 12 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19..... to 19.....I last saw him alive on 11/04/65, death is said to
have occurred on the date stated above, at 11:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due to natural causes. Deceased

(c) Due to had bilateral mid thigh
amputations, DiabetesOTHER SIGNIFICANT CONDITIONS Wellitus and arteriosclerosis
senile heart diseaseWas autopsy performed? Charles Liberman M.D. No.
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M.D.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP Date 4/12/1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 14 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP

Received and filed APR 13 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

FEMALE WHITE MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of MICHAEL J. BRENNAN
(Husband's name in full)12 AGE 83 If under 24 hours
YEARS..... MONTHS..... DAYS Hours..... MINUTES13 Usual Occupation HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) IRELAND
(State or country) MASS

17 NAME OF FATHER MICHAEL GRADY

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

19 MAIDEN NAME OF MOTHER CATHERINE McDONALD

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

21 Informant MRS ELLEN DRISCOLL

(Address) 104 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:

Paul C. Gaffney (M.D.)

(Signature of Agent of Board of Health or other)

Director of Public Health

(Official Designation)

(Date of Issue of Permit) 4/13/65

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING APR 13 1955 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.

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ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
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does not mean
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n gave rise to
a cause (a),
g the under-
cause last.

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

J.P.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

79

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



No. 26 Sturgis St. - Bay View
Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Mary E. McMahon (Leahy)
(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) Permanent Residence. No. 19 Eggleton Park
(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death years 2 months days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 12, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from March 13, 1962 to April 12, 1965
I last saw him alive on April 12, 1965 death is said to have occurred on the date stated above, at 8:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Arteriosclerotic heart

(a) disease

Due To Generalized arteriosclerosis

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Cerebral arteriosclerosis

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

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

(Print or Type Name)

(Address) 73 Bartlett Rd. Date Apr. 13, 1965
Winthrop, Mass. 02152

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

DATE OF BURIAL April 14, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

Winthrop, Mass.

ADDRESS

Received and filed APR 14 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of John F. McMahon
(Husband's name in full)

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 Own Home

15 Social Security No.

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

17 NAME OF FATHER Dennis J. Leahy

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

19 MAIDEN NAME OF MOTHER Katherine McLaughlin

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

21 Informant Catherine McDonald

(Address) 19 Eggleton Park

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

Paul E. Rafferty (M.D.)

(Signature of Agent of Board of Health or other)

Director of Public Health 4/13/65
(Official Designation) (Date of Issue of Permit)

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.

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APR 14 1965 AM

ed for burial permit
Board of Health
its Agent.

TRUCTIONS
FOR
L CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
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heart failure,
etc. It means
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 80

PLACE OF DEATH

Winthrop
(County)
Suffolk
(City or Town)



No. Bay View Nursing Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lily Wells Schmidt (Wells)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NC

(a) Residence. No. 18 FairView Street
(Usual place of abode) (City or town and State)

Length of stay: In place of death. years months 27 days. In place of residence 8 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 12 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
APRIL 22 1965, to APRIL 12 1965
I last saw her alive on APRIL 11, 1965, death is said to

have occurred on the date stated above, at 9:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCIDENT 1 DAY

Due To (b) ARTERIO-SCLEROTIC HEART DISEASE 6 YRS.

Due To (c) E CONGESTIVE FAILURE 1 DAY

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

(Signature) Myron H. King, M. D.

(Address) 120 PRESTON ST. WINTHROP, MASS. Date 4/12/65

6 Winthrop Cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 14, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed APR 13 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Henry Adolph Schmidt

(Husband's name in full)

12 AGE 73 Years 6 Months 19 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. 100-05-9068

16 BIRTHPLACE (City) New Rochelle

(State or country) New York

17 NAME OF FATHER James Wells

18 BIRTHPLACE OF FATHER (City) Glasgow

(State or country) Scotland

19 MAIDEN NAME OF MOTHER unable to obtain

20 BIRTHPLACE OF MOTHER (City) " " "

(State or country) " " "

21 Informant Henry A. Schmidt

(Address) 18 Fairview St. Winthrop

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

Paul C. Goffney

(Signature of Agent of Board of Health or other)

Director of Public Health April 13, 1965

(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.....

APR 13 1965 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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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-303

d for burial permit
Board of Health
its Agent.

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.

100W-5-64-938000

PLACE OF DEATH

SUFFOLK

(County)
WINTHROP

(City or Town)

26 Beacon St., Winthrop

No.

FRANCIS

FIORETTI

2 FULL NAME

(First Name)

(Middle Name)

(Last Name)

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

25 Harbor View Ave., Winthrop

(a) Permanent Residence. No.

3

(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 13, 1965
(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 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?

(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. Duongo, M.D.

(Print or Type Name)

(Address) Boston

Date 4/14 65

7 Woodlawn Cemetery, Everett

Place of Burial or Cremation. (City or Town)

DATE OF BURIAL April 17, 1965

8 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed APR 20 1965

A TRUE COPY ATTEST:

(Registrar)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

81

(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

3

(City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male	10 COLOR white	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN married
---------------	-------------------	--

12 If married, widowed, or divorced
HUSBAND of Rita M. Ciriello
(Give maiden name of wife in full)

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

13 AGE 35 Year 7 Months 7 Days
If under 24 hours
..... Hours Minutes

14 Usual Occupation: Teacher - Coach
(Kind of work done during most of working life)

15 Industry or Business: Winthrop Public Schools

16 Social Security No.

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

18 NAME OF FATHER Carmen Fioretti

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

20 MAIDEN NAME OF MOTHER Theresa Fazielle

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

22 Informant Mrs. Rita M. Fioretti
(Address) 25 Harbor View Ave., Winthrop

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

Gaul C. Gaffney (S)
Director of Public Health April 17, 1965
(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

APR 20 1965 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.)"

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
BIAL CERTIFICATE

T OR TYPE
S. OR CAUSES
OF DEATH

not 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 caused

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

ditions contrib-
death but not
to the terminal
condition given

T

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 207 Woodside Ave.

STANDARD
CERTIFICATE OF DEATH

Registered No.

82

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

PHYSICIAN — IMPORTANT

2 FULL NAME James E. Riley
(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) Permanent Residence. No. 207 Woodside Ave.
(Usual place of abode)

St. _____
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 15, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Sept. 19, 1961 to April 15, 1965
I last saw him live on April 15, 1965, death is said to
have occurred on the date stated above, at 7:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Squamous cell carcinoma of
the soft palate

INTERVAL
BETWEEN
ONSET AND
DEATH

3 1/2 yrs

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS diabetes mellitus

4 yrs

Was autopsy performed? no
What test confirmed diagnosis? clinical & lab

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

(Signature) M. Traunstein, Jr., M. D.
(Print or Type Name)

(Address) 73 Bartlett Rd. Date 4-15 19 65
Winthrop, Mass.

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

DATE OF BURIAL April 19 19 65

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed APR 20 1965 19 _____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed or divorced
HUSBAND of Dorothy Keefe
(Give maiden name of wife in full)

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

12 AGE 59 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

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

14 Industry or Business Insurance

15 Social Security No. _____
16 BIRTHPLACE (City) East Boston Mass
(State or country)

17 NAME OF FATHER John Riley

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

19 MAIDEN NAME OF MOTHER Mary A. Simpson

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

21 Informant Dorothy Riley
(Address) 207 Woodside Ave.

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

Paul C. Goffney (a)

(Signature of Agent of Board of Health or other)

Director of Public Health April 17 1965

(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:

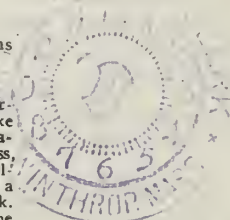
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



APR 20 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No.

83

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 A. WOODS (SOPER)

(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) Permanent Residence. No. 2 BURRILL TERRACE
(Usual place of abode)

St. WINTHROP

(City or town and State)

Length of stay: In place of death... years 6 months... days. In place of residence 4 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from May 1960, to April 16 1965

I last saw her alive on April 16 1965, death is said to have occurred on the date stated above, at 6:02 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia - Terminal

(b) Carcinomatosis

(c) Cancer of Breast (adenocarcinoma)

INTERVAL
BETWEEN
ONSET AND
DEATH

2 day

hyp.

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis? operation - X Rays

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

(Signature) Joseph Gregoire, M. D.

(Print or Type Name) JOSEPH GREGOIRE

(Address) 94 Washington St. Date 4-17 1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 19 1965

7 NAME OF FUNERAL DIRECTOR MAURILE W. KIRBY

ADDRESS WINTHROP, MASS.

Received and filed APR 20 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

FEMALE WHITE MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of CHARLES W. WOODS
(Husband's name in full)

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

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

14 Industry or Business HOME

15 Social Security No.

16 BIRTHPLACE (City) TRINITY BAY N.E.
(State or country)

17 NAME OF FATHER HENRY W. SOPER

18 BIRTHPLACE OF FATHER (City) TRINITY BAY N.E.
(State or country)

19 MAIDEN NAME OF MOTHER SARAH M. REID

20 BIRTHPLACE OF MOTHER (City) TRINITY BAY N.E.
(State or country)

21 Informant CHARLES W. WOODS
(Address) 2 BURRILL TERRACE WINTHROP

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

Paul C. Sullivan Jr.

(Signature of Agent of Board of Health or other)
Director of Public Health April 17, 1965

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

P. 15

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.

APR 20 1965 AM

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
cause, or compli-
which causedons, if any,
have rise to
cause (a),
the under-
cause last.ions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
ans to print or
e cause or
s of death on
rtificates.

1004-11-35-916145

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. 84

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

2 FULL NAME Santino Mancini

(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. 193 Trenton Street St. East Boston
(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 42 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 18 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
SEPT. 1964 to APRIL 18, 1965
I last saw him alive on 4/17/65, 1965, death is said to
have occurred on the date stated above, at 11 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) HEPATIC FAILURE

Due To CARCINOMA LIVER 7 mos.

Due To CARCINOMA LUNGS 7 mos.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NO
What test confirmed diagnosis? Biopsy - x rays5 Was disease or injury in any way related to occupation of deceased?
If so, specify.(Signed) Francis P. Schraffa M. D.
(Address) 104 Benning St. Date 4/18/656 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 22 19657 NAME OF FUNERAL DIRECTOR Anthony P. Rapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed APR 21 1965

(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 Palma Pagliccia
(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 Months Days If under 24 hours
Hours Minutes13 Usual Occupation Tailor
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 022-05-5764

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Pasquale Mancini

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

19 MAIDEN NAME OF MOTHER Josephine Sylvestri

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Palma Mancini (wife)
(Address) 193 Trenton St., East BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul E. Hoffmann
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) April 21-65 (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 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 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

nd for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not 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 caused

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

ditions contrib-
death but not
to the terminal
condition given

B.

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

C. Nora Pike (Miss)

(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) Permanent Residence. No.
(Usual place of abode)

75 Washington Ave..

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....13 days. In place of residence.....74 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHApril 25 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

April 12 1965 to April 25 1965

I last saw her alive on April 25, 1965, death is said to
have occurred on the date stated above, at 12:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular
Hemorrhage

Due To

(b) Arteriosclerosis

Due To

(c) Hypertension

INTERVAL
BETWEEN
ONSET AND
DEATH

24 hr

yo

yo

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

(Signature)

Joseph O'Regan M. D.

(Print or Type Name)

(Address)

194 Washington Ave. Winthrop, Mass. 4-20-65

6 St. Mary's Cemetery Dorchester

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

April 28 1965

7 NAME OF

FUNERAL DIRECTOR

Arthur J O'Maley

ADDRESS

Winthrop, Mass.

Received and filed

APR 27 1965

19.....

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

85

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

PHYSICIAN — IMPORTANT

2 FULL NAME

C. Nora Pike (Miss)

(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) Permanent Residence. No.
(Usual place of abode)

75 Washington Ave..

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....13 days. In place of residence.....74 years.....months.....days.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 74 Years.....Months.....Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation Retired Teacher

(Kind of work done during most of working life)

14 Industry

or Business

School

15 Social Security No.

None

16 BIRTHPLACE (City)

(State or country)

Winthrop

Mass

17 NAME OF

FATHER

Clarence Pike

18 BIRTHPLACE OF

FATHER (City)

Boston

(State or country)

Mass

19 MAIDEN NAME

OF MOTHER

Catherine J. Clair

20 BIRTHPLACE OF

MOTHER (City)

Ireland

(State or country)

21 Informant

Clarence Pike

(Address)

75 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:

Paul C. Gaffney

(Signature of Agent of Board of Health or other)

Director of Public Health

(Official Designation)

(Date of Issue of Permit)

Apr 27 1965

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.

d for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

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

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

ditions contrib-
death but not
to the terminal
condition given

B

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME

Benjamin Wiener

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

(a) Permanent Residence. No.

(Usual place of abode)

54 Cutler St.

St.

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death... years... months... 18 days. In place of residence... 15 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 26, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from March 15, 1965, to April 26, 1965.

I last saw him alive on April 25, 1965, death is said to have occurred on the date stated above, at 6:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) uremia

(b) arteriosclerotic heart disease and generalized arteriosclerosis

(c) Due To

(c) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS congestive heart failure myocardial infarction arterial thrombosis - left leg

Was autopsy performed? No

What test confirmed diagnosis? ECG Lab. Studies

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

If so, specify No

(Signature) H. B. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Shirley St. Date 4-26 1965

6 Sharon Memorial Park Sharon

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 27th 1965

7 NAME OF FUNERAL DIRECTOR

Arnold Golob

ADDRESS 1668 Beacon St. Bklyn.

Received and filed

APR 27 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

86

(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

Winthrop, Mass.

(City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

MALE White

MARRIED

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

DORA Chesnoksky

(or) WIFE of

(Husband's name in full)

12 AGE

75 Years

If under 24 hours

Hours... Minutes

13 Usual Occupation

Production Mgr.

(Kind of work done during most of working life)

14 Industry or Business

Retired

15 Social Security No.

139-01-4789

16 BIRTHPLACE (City)

Russia

(State or country)

17 NAME OF FATHER

HARRY WIENER

18 BIRTHPLACE OF FATHER (City)

Russia

(State or country)

19 MAIDEN NAME OF MOTHER

SOCH HOCHSKY

20 BIRTHPLACE OF MOTHER (City)

Russia

(State or country)

21 Informant

DR HARRY WIENER

(Address)

56 Shirley Ave. Revere

(Official Designation)

(Date of Issue of Permit)

(Date of Issue of Permit)

(Date of Issue of Permit)

(Date of Issue of Permit)

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(Date of Issue of Permit)

(Date of Issue of Permit)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

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

APR 27 1955 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.

d for burial permit
Board of Health
its Agent.

TRUCTIONS
FOR
L CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not 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 caused

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

ditions contrib-
death but not
do the terminal
condition given

B.B.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 87

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 Mr. John J. Galvin
(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) Permanent Residence. No. 15 Hale Avenue
(Usual place of abode)

St. Winthrop, Mass.
(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 APRIL 28 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
FEB 19 47 to APRIL 28 1965

I last saw him alive on APRIL 28 1965, death is said to
have occurred on the date stated above, at 1:52 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCT.

INTERVAL
BETWEEN
ONSET AND
DEATH
2 WKS.

Due To ARTERIO-SCLEROTIC +
(b) HYPERTENSIVE HEART DISEASE 14 YRS

Due To GENERAL ARTERIOSCLEROSIS
(c) 16 DAYS

OTHER SIGNIFICANT CONDITIONS
PROSTATIC ENLARGEMENT
EPROSTATIC 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

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

MYRON N. KING

(Print or Type Name)

(Address) 222 PLATT STREET Date APRIL 28 1965

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

DATE OF BURIAL April 30 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed APR 28 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Mary G. Foye
(Give maiden name of wife in full)

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

12 AGE 92 Years.....Months.....Days If under 24 hours
Hours.....Minutes

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

14 Industry or Business Restaurant

15 Social Security No. None

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

17 NAME OF FATHER Peter Galvin

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

19 MAIDEN NAME OF MOTHER Margaret Gallagher

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

21 Informant Grace G. Galvin

(Address) 15 Hale Ave., Winthrop

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

Paul C. Sullivan (Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) April 28, 1965 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER..... APR 28 1965 IM

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 IN XNLY. WITH UNPAID IN

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.)

100W-5-64-938000

X

PLACE OF DEATH

1

Middlesex

(County)

Malden

(City or Town)

No. Malden Hospital

Mary McSweeney

(McGonagle)

2 FULL NAME

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

(a) Permanent Residence. No. 179 Pauline St.,

St. Winthrop

(City or town and State)

Length of stay: In place of death.....years 2.....months.....days. In place of residence 5.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 30, 1965

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 3, 65 to April 30, 65

I last saw her alive on April 30, 1965 death is said to have occurred on the date stated above, at 6:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lymphosarcoma

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Surgery Jan. 1965

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

If so, specify

(Signature) Joseph L. Cafarella, M. D.

452 Pleasant St.,

(Address) Malden, Mass.

Date May 2/65

6 Oak Grove Medford, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL May 4, 1965

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop, Mass.

Received and filed

MAY 6 1965

19

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Malden

(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No.

88

(If death occurred in a hospital or institution, St. { 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

9 COLOR

10 SINGLE

(write the word)

Female

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

John F. McSweeney

(Husband's name in full)

12 AGE

66

Years

Months

Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation:

Home maker

(Kind of work done during most of working life)

14 Industry

or Business:

home

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Boston

Mass.

17 NAME OF

FATHER

James McDonagle

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Boston

Mass.

19 MAIDEN NAME

OF MOTHER

Julia Peters

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Maine

21 Informant

John F. McSweeney

(Address)

179 Pauline St. Winthrop

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

5-4-65

19

V 13 41

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

RECEIVED



100-17-615354H

SUFFOLK

(County)

BRIGHTON

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

BRIGHTON

(City or Town making this return)

89

 STANDARD
 CERTIFICATE OF DEATH

Registered No. 03081

No. ST. ELIZABETH'S HOSPITAL

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

PHYSICIAN — IMPORTANT

2 FULL NAME MARION B McGuire

(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 ADAMS ST

(Usual place of abode)

St. WINTHROP, MASS.

(City or town and State)

Length of stay: In place of death, 2 years, 10 months, 50 days. In place of residence, 50 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 16 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from 1-9-65, 19 65 to 3-16 19 65

I last saw her alive on 3-16 19 65 death is said to

have occurred on the date stated above, at 8:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBROVASCULAR ACCIDENT

INTERVAL
BETWEEN
ONSET AND
DEATH

(b) Due To

(c) Due To

(c) Due To

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

(Signature) Stephen A. Triandopoulos, M. D.

STEPHEN A. TRIANDOPOULOS

(Print or Type Name)

(Address) ST. ELIZABETH'S HOSP. Date 3-16 1965

6 St Patricks Cemetery Lowell Mass

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL March 20, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS

Winthrop, Mass

Received and filed MAR 19 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9. COLOR.

White

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

12-

AGE 62 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation Retired Teacher

(Kind of work done during most of working life)

14 Industry

or Business High School

15 Social Security No.

16 BIRTHPLACE (City) Lowell Mass

(State or country)

17 NAME OF

FATHER James W. McGuire

18 BIRTHPLACE OF

FATHER (City) Lowell Mass

19 MAIDEN NAME

OF MOTHER Elizabeth Hinchey

20 BIRTHPLACE OF

MOTHER (City) Lowell Mass

(State or country)

21 Informant Rev William McGuire O.M.I.

(Address) 14 Adams 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:

Carole Connors - 0307055

(Signature of Agent of Board of Health or other)

March 18 - 1965

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

26 1965

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

MAY 26 1935

FORM R-301

for burial permit
ard of Health
a Agent.DUCTIONS
OR
CERTIFICATEOR TYPE
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or each
) and (c)not mean
of dying,
art failure,
c. It means
or compli-
ch causedIf any,
e rise to
use (a),
e under-
use last.ns contrib-
th but not
e terminal
tion given

Medical Examiner will co-sign this Certificate.

PLACE OF DEATH

SUFFOLK
(County)EAST BOSTON
(City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 03158

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

PHYSICIAN — IMPORTANT

2 FULL NAME PATRICK F NEVILLE
(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) Permanent Residence. No. 33 PEBBLE AVE St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death 3 years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 18, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1960, to March 18, 1965.
I last saw him alive on March 17, 1965, death is said to have occurred on the date stated above, at 1:20 am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bilateral broncho pneumonia

(b) Due To Fracture right hip

(c) Due To Arteriosclerotic heart disease & generalized arteriosclerosis

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

15 days

5 yrs.

Was 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(Signature) M. Traubstein, Jr., M. D.
(Print or Type Name)(Address) 73 Bartlett Rd., Wintthrop, Mass. 02152
Date Mar. 18, 19656 HENRY CROSS MAIDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 22, 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS 210 WINTHROP
WINTHROP

Received and filed MAR 23 1965

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED

11 If married, widowed, or divorced HUSBAND of CATHERINE J. LYNCH.
(Give maiden name of wife in full)

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

12 AGE 90 Years.....Months.....Days If under 24 hours.....Hours.....Minutes

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

14 Industry or Business PRINTING CO.

15 Social Security No. 010-67-6749A

16 BIRTHPLACE (City) BOSTON (State or country) MASS

17 NAME OF FATHER C. H. B. I

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

19 MAIDEN NAME OF MOTHER C. H. B. I

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

21 Informant FRANCIS NEVILLE

(Address) 33 PEBBLE 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)

C 07124 3-20-65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST

26 1965

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

MAY 26 1885 AM

R-303

or burial permit
d of Health
Agent.

of Cause and Manner of Death. See reverse side for additional information. See also Chap. 14, §§ 4, 28; Chap. 45, §§ 9, 13; Chap. 114, §§ 44-47.

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

100K-9-63-936348

PLACE OF DEATH

SUFFOLK

(County)
BOSTON

(City or Town)

En route to Massachusetts General Hospital

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

(City or Town making this return)

Registered No. 03328

2 FULL NAME (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) Permanent Residence. No. 9 Johnson 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 March 23, 1965
(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 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? (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?

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

(Address) Boston Date 3/23 1965

7 Winthrop Cemetery, Winthrop

Place of Burial or Cremation. (City or Town)

DATE OF BURIAL March 26, 1965

8 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 26 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male 10 COLOR white 11 SINGLE MARRIED (write the word)
WIDOWED divorced married
UNKNOWN12 If married, widowed, or divorced
HUSBAND of Clara Musto
(Give maiden name of wife in full)

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

13 AGE 53 Years 4 Months Days If under 24 hours
Hours Minutes14 Usual Occupation: Shoe worker
(Kind of work done during most of working life)15 Industry or Business: Green Shoe Co.
022-09-447416 Social Security No. Boston
17 BIRTHPLACE (City) Mass.
(State or country)

18 NAME OF FATHER Oscar Merola

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

20 MAIDEN NAME OF MOTHER Elvira Cataldo

21 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.22 Informant (Address)
Mrs. Clara Merola
9 Johnson Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Augusta Bonanni C 07312
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

4.5

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

2112.

MAY 26 1885 AM

or burial permit
rd of Health
s Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
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EATH

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26 1965

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OUT OF - TOWN
SUFFOLK

1

PLACE OF DEATH

BOSTON

(City or Town)

Massachusetts General Hospital

No.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH
PHILLIPS HOUSE

Registered No. **03333**

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

PHYSICIAN — IMPORTANT

2 FULL NAME **Mr. Frank E. Mann**

(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. **85 Nahant 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.....days. In place of residence **20**.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF **March 24, 1965**
DEATH (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Mar 24, 1965 to **Mar 24, 1965**

I last saw him alive on **March 24, 1965**, death is said to
have occurred on the date stated above, at **4:10 P.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Myocardial Infarct**

INTERVAL
BETWEEN
ONSET AND
DEATH
7 Hrs

Due To **Coronary Arteriosclerosis**, Yrs

Due To **severe**

OTHER SIGNIFICANT CONDITIONS **Pulmonary Edema** Hrs

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

(Signature) **Charles L. Clay, M.D.**, M. D.
(Print or Type Name) **Mar. 24 65**
(Address) **Ass't. Dir., Mass. Gen'l. Hosp.** Date

6 **Puritan Lawn Cem. Peabody, Mass.**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **March 27, 1965**

7 NAME OF FUNERAL DIRECTOR **J.E. Henderson Co.**

ADDRESS **517 Broadway, Everett, Mass.**

Received and filed **William J. Hance** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of **Edna G. Lambourne**
(Give maiden name of wife in full)

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

12 AGE **58** Years **0** Months **15** Days If under 24 hours
Hours Minutes

13 Usual Occupation **Research Director**
(Kind of work done during most working life)

14 Industry or Business **Greater Boston Real Estate**

15 Social Security No. **011-05-4190**

16 BIRTHPLACE (City) **Medford** Mass.
(State or country)

17 NAME OF FATHER **Terance Mann**

18 BIRTHPLACE OF FATHER (City) **Barbado**
(State or country) **West Indies**

19 MAIDEN NAME OF MOTHER **Julia Folsom**

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

21 Informant **Mrs. Edna G. Mann**
(Address) **85 Nahant 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:

James Ballou **07320**
(Signature of Agent of Board of Health or other)

March 25, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V.I.B.

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

FORM R-301

for burial permit
ward of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
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es not mean
of dying,
heart failure,
etc. It means
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9-1965

Director
use only
AK Ink.

1-4-936348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 03559

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

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

28 Beach Road, Winthrop, Massachusetts

(a) Permanent Residence. No. St. (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 March 31, 1965
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from
March 18, 1965 to March 31, 1965

we last saw him alive March 31, 1965. Death is said to

have occurred on the date stated above, at 6:40am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia

INTERVAL
BETWEEN
ONSET AND
DEATHunknown
years.

(b) Due To

(c) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS Hypertension

Unknown

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

(Signature) Charles L. Clay, M.D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date 3-31-65

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 3, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed APR 5 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

AGE 51 Years 28 Days If under 24 hours Hours Minutes

13 Usual Occupation Assembler

(Kind of work done during most of working life)

14 Industry or Business Anelex Corp.

15 Social Security No.

BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Vincent Marotta

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

19 MAIDEN NAME OF MOTHER Anna Tasca

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

21 Informant Antonio Marotta

(Address) 59 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)

X

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

RECEIVED



JUN 29 1965 AM

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN
(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No. 03599

No. Veterans Administration Hospital

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

Albert S. MAC DONALD

PHYSICIAN — IMPORTANT

2 FULL NAME

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

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

V to 2001 10 10 10

(a) Permanent Residence. No. 62 A Temple Avenue Winthrop, Mass.

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 3 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 15, 1965, to April 3, 1965
death is said to
have occurred on the date stated above, at 5:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Cardio-pulmonary failure.

(a) Due To Status post left pneumonectomy Days

(b) Due To Massive pneumonia right lower lobe. Hours

(c) (d) Massive pulmonary emphysema right lung. Years

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes Autopsy

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

If so, specify

(Signature) Robert M. Kim M.D.

(Address) VAH, Boston, Mass. Date Apr. 4, 1965

6 Forest Hills Cemetery - Boston Mass. (City or Town)

DATE OF BURIAL April 6, 1965

7 NAME OF FUNERAL DIRECTOR Charles H. Wickens Wickens & Troupe Fun. Home

ADDRESS 46 Adams St., Quincy, Mass.

Received and filed APR 6 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Anna Albertina
(Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 67 Years 0 Months 25 Days If under 24 hours
Hours Minutes

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

14 Industry or Business Fishery

15 Social Security No 012 10 2026

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

17 NAME OF FATHER Murdock MacDonald

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

19 MAIDEN NAME OF MOTHER Catherine MacRae

20 BIRTHPLACE OF MOTHER (City) Flat River
(State or country) P.E.I. Canada

21 Informant VA Hospital Records
150 So Huntington Ave
Boston, Mass. 02130

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)
C 0754 4-7-65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
CAUSE OR CAUSES
OF DEATH

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

This does not mean
be made of dying,
such as heart failure,
sclerosis, etc. It means
the disease, or complica-
tions 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
causing the terminal
disease condition given
in (a) B.B.

9-1965

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



JUN 9 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Cambridge 95
 (City or Town making this return)

1 Middlesex
 (County)
 Cambridge
 (City or Town)

COPY OF
 CERTIFICATE OF DEATH

Registered No. 524

No. Guardian Hospital

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

2 FULL NAME Anthony Cosco
 (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) Permanent Residence. No. 104 Highland Avenue St. Winthrop, Mass.
 (Usual place of abode) (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 4, 1965
 (Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from
 March 4, 1965 to April 4, 1965
 I last saw him alive on April 4, 1965 death is said to
 have occurred on the date stated above, at 1:35 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

Due To Acute Nephritis

(c) Due To Gastric Ulcer

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

(Signature) Vincent W. Sena M. D.

(Address) 1196 Broadway, Som. 4-4 65

Woodlawn Cemetery Everett, Mass.

6 Place of Burial or Cremation April 7, 65

DATE OF BURIAL 19

7 NAME OF FUNERAL DIRECTOR Salvatore C. Parrotta

ADDRESS 314 Washington Ave. Chelsea

Received and filed MAY 12 1965

(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
 DIVORCED
 UNKNOWN Widowed

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

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

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

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

14 Industry or Business: City Employee

15 Social Security No. 031-07-2291

16 BIRTHPLACE (City) Italy
 (State or country)

17 NAME OF FATHER Pasquale Cosco

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

19 MAIDEN NAME OF MOTHER Maria Levato

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

21 Informant Ruth Hall (Cousin)

(Address) 22 Ash St. Chelsea, Mass.

A TRUE COPY

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

DATE FILED April 6, 1965

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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE July 31, 1918

DATE OF DISCHARGE Jan. 17, 1919

RANK, RATING Private

ORGANIZATION AND OUTFIT Company D 211 Regiment Engineers

SERVICE NUMBER 3011807

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NOV 14 1918

burial permit
of Health
Agent.

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9-1965

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN
(City or Town making this return)

96

03761

PLACE OF DEATH

SUFFOLK

(County)

ROXBURY

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No.

No. JEWISH MEMORIAL HOSPITAL

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

PHYSICIAN — IMPORTANT

2 FULL NAME FRANCES HERMAN

(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) Permanent Residence. No. 285 SHIRLEY

(Usual place of abode)

St. WINTHROP, MASS.

(City or town and State)

Length of stay: In place of death years months 6 days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 6 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from MARCH 31, 1965 to APRIL 6, 1965

I last saw her alive on APRIL 6, 1965, death is said to have occurred on the date stated above, at 7:00 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) SEPTICEMIA

INTERVAL BETWEEN ONSET AND DEATH

DAYS

(b) Due To URINARY TRACT INFECTION

WEEKS

+ DECUBITUS ULCER

MONTHS

(c) SACRUM, DEEP

YEARS

OTHER SIGNIFICANT CONDITIONS ARTERIO SCLEROSIS GENERALIZED

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

(Signature) P. Perez Diaz, M. D.

P. PEREZ DIAZ

(Print or Type Name)

(Address) JEWISH MEM. HOSP. Date APRIL 6, 1965

6 EMERALD ST. CONG. CEM. WOBURN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Apr. 7 19

7 NAME OF FUNERAL SOLOMON CHAPEL

ADDRESS 420 HARVARD ST. BROOKLINE

Received and Ack. APR. 8 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

12 AGE 92 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. none

16 BIRTHPLACE (City) RUSSIA (State or country)

17 NAME OF FATHER Isaac Lurensky

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

19 MAIDEN NAME OF MOTHER KATIE (c.n.b.e.)

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

21 Informant ANNA MAZER

(Address) 37 FRANCONIA AVE. NATICK

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:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



JUN 9 1965 AM

FORM R-301

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

PLACE OF DEATH



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 03953

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

PHYSICIAN - IMPORTANT

2 FULL NAME FRANK LIGHTIZER

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

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

(a) Residence, No. 137 Court Road
(Usual place of abode)

St. Winthrop

(City or town and State)

Length of stay: In place of death, 27 years, months, 27 days. In place of residence 4 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 11 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 3/15 1965 to 4/11 1965

I last saw him on 4/11 1965 death is said to have occurred on the date stated above, at 5:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Testicular Terato Carcinoma

Due To
(b)Due To
(c)

OTHER SIGNIFICANT CONDITIONS Pulmonary & Brain Metastases

INTERVAL BETWEEN ONSET AND DEATH

2 mo.

1 mo.

Was autopsy performed?

What test confirmed diagnosis? Biopsy, x-ray, scan

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

(Signature) Bruce C. Ferguson, M. D.

Bruce C. Ferguson, M. D.
(Print or Type Name)

(Address) 170 Morton St. IP Date 4/11 1965

Place of Burial or Cremation IMMEDIATE CREMATION (City or Town) MARLBOROUGH MASS

DATE OF BURIAL AP-13 65

7 NAME OF FUNERAL DIRECTOR MURRAY MURRAY INC.

ADDRESS 262 Beach St. Revere

Received and filed APR 13 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of PATRICIA TOOMEY (Give maiden name of wife in full)

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

12 AGE 38 Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business NATIONAL AIRLINES

15 Social Security No. 033-14-7443

16 BIRTHPLACE (City) Chelsea (State or country)

17 NAME OF FATHER JAMES Lightizer

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

19 MAIDEN NAME OF MOTHER MARY SULLIVAN

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

21 Informant PATRICIA Lightizer (Address) 137 Court Rd. 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) J. J. Hannon APR 12 1965

(Official Designation)

(Date of Issue of Permit)

Removed O.R. 6-15-65

46

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

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE USE OR CAUSES 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 complications which caused death.

conditions, if any, which gave rise to above cause (a), listing the underlying cause last.

Conditions contributing to death but not related to the terminal condition given.

JUN 9 - 1965

2-62-934553

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



JUN 9 1965 AM

for burial permit
ward of Health
ts Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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for each
(b) and (c)

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SUFFOLK
(County)
Winthrop
(City or Town)
Winthrop Community Hospital
No. **6-3-63**



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **98**

2 FULL NAME **Paul Basile**
(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) Permanent Residence. No. **236 Willis Ave.** St. **Medford, Mass.**
(Usual place of abode) (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 1 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **March 1965** to **1 May 1965**

I last saw him alive on **30 April 1965**, death is said to have occurred on the date stated above, at **4:30 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebral Thrombosis**

Due To **Arterio-Sclerosis**

Due To **Hypertension**

OTHER SIGNIFICANT CONDITIONS **Emphysema**

INTERVAL
BETWEEN
ONSET AND
DEATH

1 day

3 yrs.

5 yrs.

18.

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

(Signature) **John D. Latorella**, M. D.

John D. Latorella, M.D.
(Print or Type Name)

(Address) **305 Chelsea St. Medford** Date **MAY 1 1965**

6 **Oak Grove Medford**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **May 4 1965**

7 NAME OF FUNERAL DIRECTOR **Tello Russo Funeral Service**

ADDRESS **306 Main St Medford**

Received and filed **MAY 3 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed or divorced, HUSBAND of **Santa Gattarella**
(Give maiden name of wife in full)

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

12 AGE **74** Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation **General Contractor**
(Kind of work done during most of working life)

14 Industry or Business **(Retired)**

15 Social Security No. **011-03-1010**

16 BIRTHPLACE (City) **Italy**
(State or country)

17 NAME OF FATHER **Joseph Basile**

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

19 MAIDEN NAME OF MOTHER **Carmella (unknown)**

20 BIRTHPLACE OF MOTHER (City) **Italy**
(State or country)

21 Informant **Santa Basile - wife**

Address **236 Willis Ave Medford**

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

Paul C. Goffney (S)
(Signature of Agent of Board of Health or other)

Director of Public Health May 3 1965
(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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

99

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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

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

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

itions contrib-
death but not
the terminal
condition given

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No.

140 W. N. SHORE DR.

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

PHYSICIAN — IMPORTANT

2 FULL NAME NATHAN M. ALPERT
(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) Permanent Residence. No. 140 W. N. SHORE DR. St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death 16 years.....months.....days. In place of residence 16 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 2 1965
(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 5:30 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to
(b) Due to natural causes probably
(c) acute coronary occlusion
on basis of history.

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS
Winthrop Board of Health
Charles Liberman M.D.

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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 5/2/1965

6 TEFERETH ISRAEL, EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 3 1965

7 NAME OF FUNERAL DIRECTOR MURRIS W. BREZNIAK

ADDRESS 470 HARVARD ST, BROOKLINE

Received and filed MAY 3 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED

11 If married, widowed, or divorced
HUSBAND of EVA ALPERT
(Give maiden name of wife in full)

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

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

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

14 Industry or Business Real Estate

15 Social Security No. UNKNOWN

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER MURRIS ALPERT

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

19 MAIDEN NAME OF MOTHER MURRIE KUSHNER

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

21 Informant EVA ALPERT
(Address) 140 SHORE DR, WINTHROP

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

Paul C. Goffney (S)
(Signature of Agent of Board of Health or other)
Director of Public Health May 3 1965
(Official Designation) (Date of Issue of Permit)

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.

FORM R-301

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

to enter
than one
for each
(b) and (c)

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

ions, if any,
have rise to
cause (a),
the under-
cause last.

itions contrib-
leath but not
the terminal
dition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

100

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

Charles J. Jenkins

(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/O

(a) Permanent Residence, No.

442 Sumner

(Usual place of abode)

St. East Boston

(City or town and State)

Length of stay: In place of death.....years.....1 months.....7 days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHMAY 3, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased, from

April 1, 1965, to May 2, 1965

I last saw him alive on May 1, 1965, death is said to

have occurred on the date stated above, at 11:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive Pulmonary
Embolism(b) Asphyxiation -
Generator

(c) Generator

OTHER
SIGNIFICANT
CONDITIONSFemur Fracture
Carcinoma of pancreas

Was autopsy performed?

What test confirmed diagnosis?

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

If so, specify

(Signature) Joseph J. Magrath, M.D.

(Print or Type Name)

(Address) 194 Washington St. Date 5/3/65

Holy Cross

Place of Burial or Cremation

Malden
(City or Town)

DATE OF BURIAL MAY 5, 1965

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS East Boston Mass

Received and filed MAY 4, 1965

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

White

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE

82

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

Boilermaker

(Kind of work done during most of working life)

14 Industry

or Business

Retired

15 Social Security No.

012-38-3792

16 BIRTHPLACE (City)

(State or country)

East Boston Mass.

17 NAME OF FATHER

James A Jenkins

18 BIRTHPLACE OF FATHER (City)

(State or country)

Boston

MASS

19 MAIDEN NAME OF MOTHER

Catherine Carrigan

20 BIRTHPLACE OF MOTHER (City)

(State or country)

England

21 Informant

Elizabeth Jenkins

(Address)

442 Sumner 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:

Paul C. Gaffney

(Signature of Agent of Board of Health or other)

Director of Public Health

(Official Designation)

May 3, 1965

(Date of Issue of Permit)

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

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SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

St.

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

Registered No.

101

2 NAME OF FETUS Gillis, Female Twin #2
(if given)

3 DATE OF DELIVERY May 3 1965

(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

Michael Gillis

FATHER

14 MAIDEN NAME

NEVIA FAILLIA

MOTHER

PRESENT NAME NEVIA GILLIS

9 RESIDENCE, NO 221 EAST EAGLE STREET
CITY OR TOWN EAST BOSTON STATE MASS15 RESIDENCE, NO 221 EAST EAGLE STREET
CITY OR TOWN EAST BOSTON STATE MASS

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 23 (Years)

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 22 (Years)

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

13 OCCUPATION Printer

19 INFORMANT Helen Gillis

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

(a) How many children are now living? none

(b) How many children were born alive but are now dead? none

(c) How many previous fetal deaths of ANY gestation age? none

21 LENGTH OF PREGNANCY completed weeks 32

22 Weight Lb. 4 Oz.
OF FETUS (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) Constriction of umbilical cord

Due To (b) (umbilical)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

none

26 Holy Cross Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL MAY 5 196527 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH
ADDRESS EAST BOSTON

Received and filed MAY 6 1965

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE

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)If or maternal
condition causing
fetal death (do
not use such
terms as stillbirth
or prematurity.)If and/or mal-
formation conditions,
say, which gave
rise to above
(a), stating
underlying
cause last.If 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
(1).I HEREBY CERTIFY that this delivery occurred on the date stated
above at 29 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 NAME)

Address 45 Baystate St Boston Date May 4 1965

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:Paul C Gaffney Jr
(Signature of Agent or Board of Health or other)Director of Public Health 5/4/65
(Official Designation) (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.



The Commonwealth of Massachusetts

KEVIN H. WHITE

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

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

Registered No. **102**

PLACE OF DELIVERY

1

Suffolk
(County)Winthrop
(City or Town)

No.

52 Winthrop Community Hospital
52 Lincoln St. Winthrop

St. }

(If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS
(if given)

(Miri) Discenza

3 DATE OF
DELIVERYMay 5 1965
(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

Nicholas Discenza

9

RESIDENCE, NO.

527 Saratoga

STREET

CITY OR TOWN

East Boston

STATE

Mass

10 COLOR OR
RACE

White

11 AGE AT TIME OF
THIS DELIVERY

54 (Years)

12 PLACE OF
BIRTH

East Boston

Mass

(City or Town)

(State or country)

13

OCCUPATION

Custodian

MOTHER

14

MAIDEN NAME

Rita H O'Brien

PRESENT NAME

Rita H Discenza

15

RESIDENCE, NO.

527 Saratoga

STREET

CITY OR TOWN

East Boston

STATE

Mass

16 COLOR OR
RACE

White

17 AGE AT TIME OF
THIS DELIVERY

40 (Years)

18 PLACE OF
BIRTH

East Boston

Mass

(City or Town)

(State or country)

19

INFORMANT

Rita H O'Brien

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

2

(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?

none

21 LENGTH OF
PREGNANCY
completed weeks

36

22 Weight ⁴Lb.
OF FETUS
(or Grams)

Oz.

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

24 AUTOPSY

Yes

No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

Dead in Utero

Due To (b)

Tight Cord around
neck.

Due To (c)

OTHER SIGNIFICANT
CONDITIONS

None Prematurity

26 Holy Cross

Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

May 7,

19

65

27 NAME OF
FUNERAL DIRECTOR

Frederick J. Magrath

ADDRESS

325 Chelsea St. E, Boston

Received and filed

MAY 6 1965

19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 10:30 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Louis E Schraffa

M.D.

Louis E Schraffa MD

(PRINT OR TYPE NAME)

Address

49 Bennington
E Boston

Date

May 5 1965

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

Paul C. Goffney

(Signature of Agent of Board of Health or other)

Director of Public Health

May 6, 1965

(Official Designation)

(Date of Issue of Permit)

11-51035 F11



11-51035 F11

FETAL DEATH

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

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for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

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

ons, if any,
have rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 103

No. Winthrop Community Hospital

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

PHYSICIAN — IMPORTANT

2 FULL 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) Permanent Residence. No. 329 Winthrop Street

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....1 days. In place of residence.....years.....months.....2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 8 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
May 1, 1965 to May 8, 1965.I last saw him alive on May 8, 1965, death is said to
have occurred on the date stated above, at 8:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To pulmonary fibrosis 3 days

(b) Due To

(c) OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? X-Rays

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

(Signature) H. B. Greenfield M. D.

(Address) 447 Springfield St. Date 5-9 1965

6 St. Philips Grafton
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 12, 1965

7 NAME OF FUNERAL DIRECTOR Miss Mary E. Greenfield

ADDRESS 250 Main St. South Grafton

Received and filed MAY 10 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of M. Adeline Dupuis
(Give maiden name of wife in full)

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

12 AGE 68 Years Months Days 13 If under 24 hours
Hours Minutes13 Usual Occupation Meat Cutter (Retired)
(Kind of work done during most of working life)

14 Industry or Business Chicago Dressed Meat

15 Social Security No. 020-16-0215

16 BIRTHPLACE (City) Northbridge, Mass.
(State or country)

17 NAME OF FATHER Gilbert Cote

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

19 MAIDEN NAME OF MOTHER Lydia Eastman LAFLAM

20 BIRTHPLACE OF MOTHER (City) Montpelier,
(State or country) Vermont

21 Informant Mrs. Barbara E. Deyette (Daughter)

(Address) 19 Oak St. Grafton, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Giffney (C)
(Signature of Agent of Board of Health or other)Director of Public Health May 10 1965
(Official Designation) (Date of Issue of Permit)

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:

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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.

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)

No. 160 Court Road


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

 STANDARD
 CERTIFICATE OF DEATH

Registered No. 104

 d for burial permit
 ard of Health
 Agent.

 INSTRUCTIONS
 FOR
 IL CERTIFICATE

 OR TYPE
 OR CAUSES
 DEATH

 not enter
 e: than one
 ate for each
 a (b) and (c)

 does not mean
 le of dying,
 e heart failure,
 i etc. It means
 use, or compli-
 e which caused

 ons, if any,
 e gave rise to
 u cause (a),
 is the under-
 g cause last.

 Conditions contrib-
 t death but not
 o the terminal
 e condition given

PLACE OF DEATH

2 FULL NAME

Bridget Dowd (Wickham)

(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. 160 Court Road
 (Usual place of abode)

 St. Winthrop
 (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH MAY 10 1965
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
 MAR 21 1965, to 5/10 1965

 I last saw h alive on 5/10 1965, death is said to
 have occurred on the date stated above, at 22 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO-SCLEROTIC HEART DIS

 Due To C CONGESTIVE FAILURE 2MO
 (b) + ACUTE PULMONARY

 Due To ED EMA
 (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

(Signature) MYRON N. KING M.D.

 MYRON N. KING M.D.
 (Print or Type Name)

(Address) 160 COURT RD, DATE 5/11 1965

 6 Place of Burial or Cremation
 WINTHROP (City or Town)

DATE OF BURIAL May 13, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAY 12 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

 12 AGE 68 Years 3 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.

 16 BIRTHPLACE (City) Derrigimlagh
 (State or country) Ireland

17 NAME OF FATHER Patrick Wickham

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

19 MAIDEN NAME OF MOTHER Mary Conneely

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

 21 Informant Stephen Dowd
 (Address) 160 Court Rd., Winthrop

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

 Paul C. Goffney
 (Signature of Agent of Board of Health or other)
 Director of Public Health May 12, 1965
 (Official Designation) (Date of Issue of Permit)

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 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 DELIVERY

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 NAME OF FETUS ~~STILLBORN~~ BOY MAHONEY
(if given)

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. 105

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)3 DATE OF DELIVERY 5/10/65
(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 FATHER
FULL NAME Paul D Mahoney
RESIDENCE, NO. 194 Falcon St STREET
CITY OR TOWN East Boston STATE Mass
10 COLOR OR RACE W. 11 AGE AT TIME OF THIS DELIVERY 25 (Years)
12 PLACE OF BIRTH East Boston Mass
(City or Town) (State or country)
13 OCCUPATION Truck Driver

14 MOTHER
MAIDEN NAME Marianne L Hutchinson
PRESENT NAME Mahoney
RESIDENCE, NO. 194 Falcon St STREET
CITY OR TOWN East Boston STATE Mass
16 COLOR OR RACE W. 17 AGE AT TIME OF THIS DELIVERY 22 (Years)
18 PLACE OF BIRTH Wintthrop, Mass.
(City or Town) (State or country)
19 INFORMANT Paul D Mahoney

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

21 LENGTH OF PREGNANCY 35 completed weeks	22 WEIGHT OF FETUS Lb. 17 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) Erythroblastosis fetalis
Due To (b)
Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 Woodlawn Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 14 1965

27 NAME OF FUNERAL DIRECTOR Ernest P. Gagnan
ADDRESS 147 Wintthrop St Wintthrop

Received and filed MAY 14 1965 19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 4:55 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
Myron N. King M.D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

Address 222 PLEASANT ST Date 5/12/65
WINTHROP MASS

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

Paul C. Gaffney
(Signature of Agent of Board of Health or other)
Director of Public Health May 14 1965
(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)al or maternal
condition causing
fetal death (do
not use such
terms as stillbirth
or prematurity.)al and/or mal-
formation, con-
ditions, which
gave rise to above
cause (a), stating
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).

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.

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
L CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
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
to the terminal
condition given

P.B.

X

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 36 Bellevue Ave

2 FULL NAME

Gregory Cosgrove

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

(a) Permanent Residence. No. 36 Bellevue Ave

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death. 26 years.....months.....days. In place of residence. 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 14 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY 8 1965, to MAY 14 1965

I last saw him alive on May 14 1965, death is said to have occurred on the date stated above, at 6:08 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Stomach

INTERVAL
BETWEEN
ONSET AND
DEATH

6 Mos

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

None

Was autopsy performed? No

What test confirmed diagnosis? Clinical Findings

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

(Signature) John F. Collins, M.D.

John F. Collins M.D.

(Print or Type Name)

(Address) Revere Mass Date 15 May 1965

6 Winthrop

Winthrop

Place of Burial or Cremation

May 17 65

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed

MAY 17 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 78 106

(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
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Mabel Cosgrove (Deverell)
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 78 1 Months 1 Days
If under 24 hours
Hours Minutes13 Usual Occupation Purveyor
(Kind of work done during most of working life)

14 Industry or Business Wholesale Meats

15 Social Security No. 022-03-5957

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

17 NAME OF FATHER Michael Cosgrove

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

19 MAIDEN NAME OF MOTHER Josephine Myer

20 BIRTHPLACE OF MOTHER (City)
(State or country) Massachusetts21 Informant Mabel Cosgrove
(Address) 36 Bellevue 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:

Paul C. Goffney (M.D.)

(Signature of Agent of Board of Health or other)

Director of Public Health 5/17/65
(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.

MAY 17 1965 AM



FORM R-301

for burial permit
board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

does 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.

ditions contrib-
death but not
to the terminal
condition given

B.

Medical Examiner Notified - Referred to Board of Health.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

44 Cliff Ave.

No.

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

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

44 Cliff Ave.

(a) Permanent Residence. No. St.
(Usual place of abode) 7 (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 16 1965
(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 7:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death - presumably due to

(b) Due To natural causes.

(c) Due To Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS 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

(Signature) CHARLES LIBERMAN M.D.
Charles Liberman

(Address) WINTHROP, MASS. Date 5/17/1965
(Print or Type Name)

6 Woodlawn Crematory Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 19 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed MAY 17 1965 19.....

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 107

PHYSICIAN - IMPORTANT

(Was deceased a No
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
DIVORCED Married
UNKNOWN

11 If married, widowed or divorced
HUSBAND of Euphemia McKinlay
(Give maiden name of wife in full)

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

12 AGE 52 Years 6 Months 11 Days If under 24 hours
Hours Minutes

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

14 Industry or Business Restaurant Co.

15 Social Security No. Paisley
16 BIRTHPLACE (City) Scotland
(State or country)

17 NAME OF FATHER John Laing
18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)
19 MAIDEN NAME OF MOTHER Helen Johnston
20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)

21 Informant Euphemia Laing
(Address) 44 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:

Paul C. Halliway (M.D.)
(Signature of Agent of Board of Health or other)
Director of Public Health 5/17/65
(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.

MAY 12 1965 AM

The Commonwealth of Massachusetts

FORM R-301

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 108

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 Frederick J. O'Connell
(If deceased is a married, widowed or divorced woman, give also maiden name.)

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

(a) Permanent Residence. No. 242 Main St. st. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death years 1 months days. In place of residence 34 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from May 16 1965 to May 16 1965

I last saw him alive on May 16 1965 death is said to have occurred on the date stated above, at 1458

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage massive

Due To (b) arteriosclerosis generalized

Due To (c)

OTHER SIGNIFICANT CONDITIONS Myocardial Heart Disease - Chronic

Was autopsy performed? No

What test confirmed diagnosis? Chronic

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

(Signature) Joseph J. Gonzalez M. D.

(Print or Type Name) JOSEPH J. GONZALEZ

(Address) 194 Washington St. Date 5/16/65

Winthrop Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 19 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP

Received and filed MAY 18 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

11 If married, widowed, or divorced HUSBAND of AGNES B. DONOGHUE (Give maiden name of wife in full)

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

12 AGE 72 Years Months Days 13 If under 24 hours Hours Minutes

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

14 Industry or Business M.T.B. & A.

15 Social Security No. 024-19-3411

16 BIRTHPLACE (City) FLEMINGHAM MASS (State or country)

17 NAME OF FATHER MICHAEL J O'CONNELL

18 BIRTHPLACE OF FATHER (City) HULLISTON MASS (State or country)

19 MAIDEN NAME OF MOTHER MARY J (Hyden) (State or country)

20 BIRTHPLACE OF MOTHER (City) WALTHAM MASS (State or country)

21 Informant MRS AGNES O'CONNELL

(Address) 242 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:

Paul C. Rafferty (M.D.) (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation)

(Date of Issue of Permit) 5/18/65

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

JUNE 22, 1916

DATE OF DISCHARGE.....

April 28, 1919

RANK, RATING

Sergeant

ORGANIZATION AND OUTFIT.....

101st Infantry, 26th Division

SERVICE NUMBER.....

60125

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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M R-303

for burial permit
ard of Health
ts Agent.

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.

100W-5-611-938000

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 DEATH

(City or Town making this return)

Registered No. 109

En route to Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY P ROSS (Barry)
(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) Permanent Residence. No. 236 Main Street, Winthrop St. (City or town and State)

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 May 18, 1965
(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.)

Arteriosclerotic and hypertensive heart disease.

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 (Print or Type Name) Date 5/18 65

7 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 22 19 65

8 NAME OF DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop Mass
St., Winthrop

Received and filed MAY 20 1965 19

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)

Female White MARRIED WIDOWED DIVORCED UNKNOWN Widowed

12 If married, widowed, or divorced

HUSBAND of

Irving Ross wife in full)

(or) WIFE of

name in full)

13 AGE 70 Year 3 Months 1 Day If under 24 hours

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

15 Industry or Business: At Home

16 Social Security No. 031-34-2151
Boston17 BIRTHPLACE (City) Mass
(State or country)

18 NAME OF FATHER Thomas Barry

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

20 MAIDEN NAME OF MOTHER Mary Kane

21 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)22 Informant (Address) Joseph Ross
83 Summit Rd, Medford

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

Paul C. Gaffney
(Signature of Agent of Board of Health or other)Treasurer of Public Health May 20, 1965
(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 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.)"

for burial permit
ard of Health
ts Agent.

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CERTIFICATE

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heart failure,
etc. It means
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death but not
the terminal
dition given

B.B.

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop

(City or Town)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 110

No. 202 Grovers Avenue

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

PHYSICIAN — IMPORTANT

2 FULL NAME JACOB GROMAN

(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. 202 Grovers Avenue
(Usual place of abode)

St. Winthrop
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 19 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
FEB-8, 1962 to MAY 19, 1965
I last saw him live on MAY 18, 1965, death is said to
have occurred on the date stated above, at 3:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY THROMBOSIS 15 MIN

Due To (b) ATERIOSCLEROTIC HEART DISEASE 4 YRS

Due To (c) ARTERIOSCLEROSIS 4 YRS

OTHER SIGNIFICANT CONDITIONS
DIABETES MELLITIS
AMPUTATION RIGHT LEG
TWO TOES LEFT FOOT

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

(Signature) G. D. Caplan, M. D.

A. N. CAPLAN M.D.
(Print or Type Name)

(A) 166 PRINCETON ST. BOSTON Date 5-19-1965

6 Tifereth Israel Cemetery* Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 20, 1965

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLOV

ADDRESS 1668 BEACON STREET, BROOKLINE

Received and filed MAY 20 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED MARRIED
DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Frances B Zaks
(Give maiden name of wife in full)

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

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

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

14 Industry or Business State Oil Company Inc.

15 Social Security No. 018-18-1002

16 BIRTHPLACE (City) Lithuania
(State or country)

17 NAME OF FATHER Philip Groman

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

19 MAIDEN NAME OF MOTHER Trina Baron

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

21 Informant Frances B. (Zaks) Groman

(Address) 202 Grovers Ave. Winthrop

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

Paul C. Buffney
(Signature of Agent of Board of Health or other)

Director of Public Health May 20 1965
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING50.....
 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.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

does not mean
of dying,
heart failure,
etc. It means
cause, 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

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

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)

Registered No.

111

PHYSICIAN — IMPORTANT

2 FULL NAME Martha Hagnan (Southard)
(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) Permanent Residence. No. 152 Quincy Ave., St. Winthrop
(Usual place of abode) (City or town and State)

Length of stay: In place of death, 19 years, 19 months, 19 days. In place of residence, 55 years, 55 months, 55 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 21 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
May 2, 1965, to May 21, 1965

I last saw her alive on May 21, 1965 death is said to
have occurred on the date stated above, at 7:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Embolus 19 days

Due To Arteriosclerotic heart disease

(b) 2 yrs.

Due To Arteriosclerosis, general

(c) 4 yrs.

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical findings

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

If so, specify

(Signature) John F. Collins M.D.

John F. Collins M.D.
(Print or Type Name)

(Address) Revere, Mass. Date May 21 1965

6 Woodlawn Crematory Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 24 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed MAY 24 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

12 AGE 78 Years 1 Months 5 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) East Boston
(State or country) Mass

17 NAME OF FATHER Abraham Southard

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

19 MAIDEN NAME OF MOTHER Madge Kelly

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

21 Informant Arthur Hagnan

(Address) 152 Quincy 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)

Director of Public Health May 24 1965
(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.....
.....

MAY 2 1935

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.

ORM R-301

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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

oes not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
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cause (a),
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death but not
the terminal
condition given
B.B.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



Suffolk
(County)

Winthrop
(City or Town)

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 112

No. Cliff House Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Gertrude May Tewksbury (Taylor)
(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) Permanent Residence. No. 494 Shirley St. St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 25 years 65 months 65 days. In place of residence 65 years 65 months 65 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 26 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
September 29 52 to May 26, 19 65
I last saw him alive on May 26, 19 65 death is said to
have occurred on the date stated above, at 12 M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Arteriosclerotic and

(a) Hypertensive heart disease 10 yrs.

Due To Generalized
(b) arteriosclerosis 12 yrs.

Due To Cerebral arteriosclerosis
(c) 1 yr.

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

(Signature) M. Traustein Jr. M. D.

M. Traustein, Jr., M. D.

(Address) 73 Bartlett Rd. May 27, 1965
Winthrop, Mass.

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

DATE OF BURIAL May 29 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed MAY 28 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)
(or) WIFE of Albertus Tewksbury
(Husband's name in full)

12 AGE 87 Years 7 Months 20 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. 011-26-9018-A

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

17 NAME OF FATHER Albertus Taylor

18 BIRTHPLACE OF FATHER (City) Strong
(State or country) Maine

19 MAIDEN NAME OF MOTHER Sarah Frances Keene

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

21 Informant Mildred B. Davis

(Address) 494 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:

Paul C. Goffney
(Signature of Agent of Board of Health or other)
Director of Public Health May 28, 1965
(Official Designation) (Date of Issue of Permit)

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.

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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.

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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than one
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(b) and (c)

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heart failure,
etc. It means
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the terminal
condition given
BB.

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 113

No. WINTHROP COMMUNITY HOSPITAL

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

CORA (WEISE) KELEHER

PHYSICIAN — IMPORTANT

2 FULL 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. 3 Woodside Park
(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.....50.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 27 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec 17, 1960, to May 27, 1965
I last saw her alive on May 27, 1965 death is said to

have occurred on the date stated above, at 9:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction 1 hour

Due To (b) Atherosclerotic heart disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS Congestive heart failure
Pulmonary fibrosis

Was autopsy performed? No

What test confirmed diagnosis?

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

(Signature) H. B. Greenfield, M. D.

(Address) 447 Shirley St. Winthrop Date 5-27-65

6 Holyhood Cemetery Brookline
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 29 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed MAY 28 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

(or) WIFE of Albert E. Keleher (Husband's name in full)

12 AGE 78 Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Patterson New Jersey (State or country)

17 NAME OF FATHER Gustave Weise

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

19 MAIDEN NAME OF MOTHER Anna Koch

20 BIRTHPLACE OF MOTHER (City) New York (State or country)

New York

21 Informant Albert E. Keleher (Address)

97 Edgebrook Rd Framingham Mass

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

Paul C. Gallner, Jr. (Signature of Agent of Board of Health or other)

Director of Public Health May 27 1965 (Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Removed 18 5-27-65

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

(County)
WINTHROP

(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No. 114

No. 162 BOWDOIN ST.

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

PHYSICIAN — IMPORTANT

2 FULL NAME TERESA BACHINI (CASTELLO

(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. 162 BOWDOIN ST.

(Usual place of abode)

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

Length of stay: In place of death 37 years months days. In place of residence 37 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 29 1965
(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 8:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To natural causes.

(b) Winthrop Board of Health

Due To Charles Liberman M.D.

(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) Charles Liberman M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 238 Shore Dr. Date 5/29/65

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 1 1965

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St. Winthrop

Received and filed JUN 1 1965

(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 Dante Bachini
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 0 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: At Home

15 Social Security No. Dublin

16 BIRTHPLACE (City) Ireland
(State or country)

17 NAME OF FATHER John Castello

18 BIRTHPLACE OF

FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary Moore

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

21 Informant Leo Bachini St., Winthrop.
(Address) 297 Winthrop Mass

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

Emil C. Goffney (P)
(Signature of Agent of Board of Health or other)

Director of Public Health 5/29/65
(Official Designation) (Date of Issue of Permit)

R-301A

ACTIONS
OR
CERTIFICATE

iving
OF DEATH

t enter
han one
for each
b) and (c)

s not mean
of dying,
heart failure,
c. It means
or compli-
which caused

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ons contrib-
ath but not
the terminal
dition given

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

59-925686

Medical examiners notified. Referred to Board of Health.

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 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.)

100M-9-63-936348

PLACE OF DEATH

Essex

(County)

Lynn

(City or Town)

No. Lynnview Hospital



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Lynn

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 115

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

2 FULL NAME Lucy Stevenson (Pick) { (Was deceased a
(If deceased is a married, widowed or divorced woman, give also maiden name.) U. S. War Veteran, ---
if so specify WAR)

(a) Permanent Residence. No. 59 Summit Ave. St. Winthrop
(Usual place of abode) (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 29, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 5/25, 1965, to 5/29, 1965.
I last saw her alive on 5/29, 1965, death is said to have occurred on the date stated above, at 5:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Basilar artery thrombosis 1 Mo.

Due To (b) _____

Due To (c) _____

OTHER SIGNIFICANT CONDITIONS Arteriosclerosis ---

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 _____

(Signature) Clarence London, M. D.

370 Summer St.

(Address) Lynn, Mass. Date 5/30 19 65

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 1, 19 65

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed JUN 9 - 1965 19 65

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX <u>female</u>	9 COLOR <u>white</u>	10 SINGLE (write the word) <u>MARRIED</u> <u>WIDOWED</u> <u>DIVORCED</u> <u>UNKNOWN</u>
------------------------	-------------------------	---

11 If married, widowed, or divorced
HUSBAND of Andrew Stevenson (Give maiden name of wife in full)
(or) WIFE of _____ (Husband's name in full)

12 AGE 94 years 10 Months 6 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) Nova Scotia
(State or country)

17 NAME OF FATHER Leonard Pick

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

19 MAIDEN NAME OF MOTHER Sarah Duncanson

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

21 Informant Louis Pick
(Address) 11 Washington Terr.
New York City

A TRUE COPY
ATTEST: Albert L. Slyme
(Registrar of City or Town where death occurred)

DATE FILED June 1/65 19 65

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



for burial permit
Board of Health
Agent.

DUCTIONS
FOR
CERTIFICATE

OR TYPE
CAUSES
DEATH

enter
than one
for each
b) and (c)

es not mean
of dying,
heart failure,
etc. It means
or compli-
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ve rise to
ause (a),
the under-
ause last.

ions contrib-
eath but not
the terminal
dition given

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 116

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 MALCOLM L. JONES
(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. 124 RIVER ROAD
(Usual place of abode)

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

Length of stay: In place of death.....years.....months.....2.....days. In place of residence.....58.....years.....5.....months.....8.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 30 65
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Oct 10, 19 64, to May 30, 19 65

I last saw him alive on May 30, 19 65, death is said to
have occurred on the date stated above, at 3:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinoma of plate + pharynx

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To metastasis 8 mos
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Biopsy

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

(Signature) H. B. Greenfield, M. D.

(Print or Type Name)

(Address) 477 North St Wintthrop Date 5-30 19 65

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

DATE OF BURIAL June 2 19 65

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed JUN 2 - 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

12 AGE 58 Years 5 Months 8 Days If under 24 hours
Hours Minutes

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

14 Industry or Business: Industrial Supplies

15 Social Security No. 022-03-0539

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

17 NAME OF FATHER John L Jones

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

19 MAIDEN NAME OF MOTHER Mary E MacNiven

20 BIRTHPLACE OF MOTHER (City) New York City
(State or country) New York

21 Informant Elsie Jones
(Address) 124 River Rd. Wintthrop, Mass.

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

Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health June 2 1965
(Official Designation) (Date of Issue of Permit)

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 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.

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.)

R-305

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Denvers

(City or town making return)

Registered No. 117

Essex

(County)

Denvers

(City or Town)



COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

No. Denvers State Hospital

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

2 FULL NAME Sadie Kooris (Solovachek)

(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.

(Usual place of abode)

Denvers State Hospital

(If nonresident, give city, town and State)

Length of stay: In place of death.....years.....5 months.....6 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 3 1965
(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.)

Generalized arteriosclerosis

gastro enteritis with dehydration

5 Accident, suicide, or homicide (specify) NO

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

(How did injury occur?)

Nature of

Injury

NO

NO

While at work? Was autopsy performed?

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

If so, specify Arthur W. O'neil

(Signed) Arthur W. O'Neil, M. D.

(Address) Salem, Mass. Date March 3, 1965

7 Place of Burial or Cremation Public Health Cemetery (City or Town)

DATE OF BURIAL March 5, 1965

8 NAME OF FUNERAL DIRECTOR Solomon Funeral Home

ADDRESS Brookline, Mass.

Received and filed 3-6-65 1965

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 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

Harry Kooris

(Husband's name in full)

13 DATE OF BIRTH 70 10 15

14 AGE.....Years.....Months.....Days.....Retired If under 24 hours Hours.....Minutes

15 Usual

Occupation:

(Kind of work done during most of working life)

16 Industry

or Business:

033-2617-20

East Boston

17 Social Security No.

18 BIRTHPLACE (City)

(State or country)

Abraham Solovachek

19 NAME OF

FATHER

Unknown

20 BIRTHPLACE OF

FATHER (City)

Russia

(State or country)

21 MAIDEN NAME

OF MOTHER

Ida Miller

Unknown

22 BIRTHPLACE OF

MOTHER (City)

Russia

(State or country)

Helen A. Polkowski

23 Informant

(Address)

Denvers, Mass.

A TRUE COPY.

ATTEST:

(Registrar of City or Town where death occurred)

Trocy I. Flagg

DATE FILED

Public Health March 11, 1965



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 in which the death occurred, 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.)

100M-5-64-25000

X
PLACE OF DEATH
I

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 118

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 Charles E. Cooper
(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) Permanent residence. No.

170 2/15/65

St. Winthrop, Mass

(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 March 31 1965
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
March 3 1965, March 31 1965
I last saw him alive on March 31 1965, death is said to
have occurred on the date stated above, at 9:10 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Focal acute Pneumonia

INTERVAL
BETWEEN
ONSET AND
DEATH
Days

(b) XXXXX Arteriosclerotic Hrt. Dis Yrs.

(c) Due To Generalized arteriosclerosis 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

(Signature) Willard M. Hausman
Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 3-31-65

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

DATE OF BURIAL April 3 1965

7 NAME OF FUNERAL DIRECTOR Kirby Funeral Home
Winthrop, Mass

ADDRESS 3-31-65

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 WIDOWED DIVORCED UNKNOWN
widowed

11 If married, widowed, or divorced
HUSBAND of Florence MacIsaac
(Give maiden name of wife in full)

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

12 AGE 86 1 24 Days
Years Months Days If under 24 hours
Hours Minutes

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

14 Industry or Business

15 Social Security No. 010-09-7057A

16 BIRTHPLACE (City) New Haven
(State or country) Conn

17 NAME OF FATHER James W. Cooper

18 BIRTHPLACE OF FATHER (City) New Haven
(State or country) Conn

19 MAIDEN NAME OF MOTHER Maggie L. Doty

20 BIRTHPLACE OF MOTHER (City) Long Island
(State or country) New York

21 Informant Helen A. Ziolkowski

(Address) Danvers, Massachusetts

A TRUE COPY Tracy I. Flagg

ATTEST: Dir of Public Health (Registrar of City or Town where death occurred) 3-31-65

DATE FILED 19.

X

SPACE FOR ADDITIONAL INFORMATION RECEIVED.....

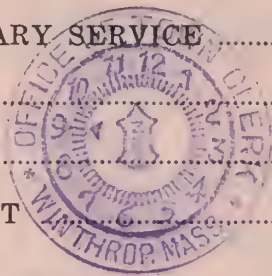
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



JUN 15 1965 AM

FORM R-301

Filed for burial permit
with Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
USE OR CAUSES
OF DEATH

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

This does not mean
mode of dying,
such as heart failure,
pneumonia, etc. It means
disease, or complica-
tions which caused
death.

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

Conditions contrib-
uting to death but not
related to the terminal
disease condition given
in (a).

PLACE OF DEATH

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)

No. Peter Bent Brigham Hospital

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

(a) Permanent Residence. No. 123 Herman St. Winthrop, Mass.

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 22 1965
(Month) (Day) (Year)

WE HEREBY CERTIFY That we attended deceased from
Jan 22 1965 to April 22 1965
we last saw him live on April 22 1965 death is said to
have occurred on the date stated above, at 6:50 PM

DEATH WAS CAUSED BY IMMEDIATE CAUSE

(a) Carcinoma of bladder

(b) Due To Hydronephritis

(c) Due To Acute pyelonephritis

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

(Signature) John Grove, M. D.

John Grove
(Print or Type Name)

(Address) PBBH Date April 22 1965

6 St. Michael's Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 26 1965

7 NAME OF FUNERAL DIRECTOR Domenic J. Russo

ADDRESS 407 Main St. Medford

Received and filed APR 27 1965

William J. Kane
(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 119 04372

(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 VARS) No

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed or divorced
HUSBAND of Concetta Peloso
(Give maiden name of wife in full)

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

12 AGE 77 Years 8 Months Days If under 24 hours
Hours Minutes

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

14 Industry of Business Retired

15 Social Security No. 025-14-7206

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Domenico Peloso

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

19 MAIDEN NAME OF MOTHER Domenica - unknown

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

21 Informant Margaret Thomas

(Address) 123 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:
E. J. Russo
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.

RECEIVED



JUN 29 1965 AM

burial permit
of Health
Agent.

ATIONS
RTIFICATE

TYPE
CAUSES
ATH

enter
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or each
and (c)

not mean
of dying,
failure,
It means
or compli-
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If any,
rise to
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under-
se last.

as contrib-
th but not
a terminal
tion given

3.

129 1965

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)
128
164376
Registered No.

PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)



No. University Hospital

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

PHYSICIAN — IMPORTANT

2 FULL NAME Isaac Schair
(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) Permanent Residence. No. 44 Carol Avenue St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death, years months 27 days. In place of residence, 42 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 22 1965
(Month) (Day) (Year)
4 I HEREBY CERTIFY, That I attended deceased from
3/30/65, 1965, to 4/22/65, 1965

I last saw him alive on 4/22 1965, death is said to
have occurred on the date stated above, at 10:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lymphoma

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis? Bone marrow biopsy

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

(Signature) Peter J. Quisenberry, M. D.
Peter J. Quisenberry

(Address) University Hospital Date 4/22/1965

6 Beth El West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 25 1965

7 NAME OF FUNERAL DIRECTOR Henry Levine

ADDRESS 479 Harvard St. Brookline

Received and filed APR 27 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Annie Cohen
(Give maiden name of wife in full)

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

12 AGE 71 Years Months Days If under 24 hours
Hours Minutes

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

14 Industry or Business Fuel Business

15 Social Security No. 011-26-9054

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Samuel Schair

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

19 MAIDEN NAME OF MOTHER Mollie Krute

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

21 Informant Mr. Burton Schair

(Address) 1000 Washington St. Braintree

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) April 24 1965
(Date of Issue of Permit)

A TRUE COPY ATTEST:

Removed 4.29.65

V.B.

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

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JUN 29 1965 AM

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



(City or Town making this return)

121

Registered No. 14339

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)

No. Beth Israel Hospital

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

PHYSICIAN — IMPORTANT

2 FULL NAME

Sheltry Baby Girl

(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) Permanent Residence. No.
(Usual place of abode)

11 Whittier

St. Winthrop
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 22 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 22, 1965, to April 22, 1965.

I last saw her alive on April 22, 1965, death is said to
have occurred on the date stated above, at 10:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Ancephalus

Due To (b) prematurity of 33 weeks

Due To (c) gestation.

INTERVAL
BETWEEN
ONSET AND
DEATH

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

(Signature) June O. Lee, M. D.

June O. Lee
(Print or Type Name)

(Address) Beth Israel Hosp Date April 22, 1965

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

DATE OF BURIAL April 23 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. Moley

ADDRESS Winthrop, Mass

Received and filed APR 27 1965 APR 27 1965

William J. Kane
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

12 AGE Years 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 Sheltry

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

19 MAIDEN NAME OF MOTHER Claire Virrell

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

21 Informant Joseph Sheltry

(Address) 11 Whittier St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death

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

Signature of Agent of Board of Health or other
(Date of Issue of Permit) April 23 1965

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST.

A TRUE COPY ATTEST: \

William J. Kane.

City Registrar

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JUN 29 1965 AM

FORM R-301

The Commonwealth of Massachusetts

SUFFOLK

(County)

BOSTON

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 04474

N. MASSACHUSETTS GENERAL HOSPITAL

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

PHYSICIAN — IMPORTANT

 2 FULL NAME Mabel G. Fors (CURRIE)
 (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) Permanent Residence. No. 40 Fremont St., Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months. 2 days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH April 25, 1965
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
 April 25, 1965, to April 25, 1965, 19.....

 I last saw him alive on April 25, 1965, 19..... death is said to
 have occurred on the date stated above, at 12/15 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Infarction

INTERVAL
BETWEEN
ONSET AND
DEATH

5 days

(b) Coronary Thrombosis

5 days

(c) Coronary Atherosclerosis Years

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus 10 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

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Ass'n. Dir., Mass. Gen'l. Hosp. Date 4/25/65 19.....

 6 WINTHROP CEM. WINTHROP.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 28 1965

 7 NAME OF FUNERAL DIRECTOR MAURILE W. HIRBY
 210 WINTHROP ST
 ADDRESS WINTHROP, MASS.

Received and filed APR 28 1965 19.....

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of CARL G. FORS (Husband's name in full)

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

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

14 Industry or Business: HOME

15 Social Security No. 027-14-2287

16 BIRTHPLACE (City) ST. JOHN N.B.
(State or country)

17 NAME OF FATHER ROBERT CURRIE

 18 BIRTHPLACE OF FATHER (City) ST. JOHN
 (State or country) N.B.

19 MAIDEN NAME OF MOTHER ANNIE HUGHSON

 20 BIRTHPLACE OF MOTHER (City) ST. JOHN
 (State or country) N.B.

21 Informant CARL G. FORS

(Address) 40 FREMONT 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:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

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JUN 29 1965 AM

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Medical Examiner notified - Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. **123**

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)No. **36 TAYLOR ST.**(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME **FRANCIS W. McEACHERN**
(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 2**(a) Permanent Residence. No. **36 TAYLOR ST**
(Usual place of abode)St. **WINTHROP**
(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 **June 2, 1965**
(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 **8:00 P.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH(a) **Death presumably due**(b) **to natural causes**Due To **Winthrop Board of Health**(c) **Charles Liberman M.D.**OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? **No**

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased **No**
If so, specify(Signature) **Charles Liberman**, M. D.
CHARLES LIBERMAN
(Print or Type Name)(Address) **WINTHROP, MASS.**, Date **6/2/1965**6 **HOLY CROSS** **MALDEN**
Place of Burial or Cremation (City or Town)DATE OF BURIAL **JUNE 4, 1965**7 NAME OF FUNERAL DIRECTOR **MAURICE W. NIBBY**ADDRESS **WINTHROP**Received and filed **JUN 3 - 1965**, 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN **SINGLE**

11 If married, widowed, or divorced

HUSBAND of
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE **50** Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation **TECHNICIAN**
(Kind of work done during most of working life)14 Industry or Business **ELECTRONICS**15 Social Security No. **010-07-0654**16 BIRTHPLACE (City) **WINTHROP**
(State or country) **MASS.**17 NAME OF FATHER **JOHN A McEACHERN**18 BIRTHPLACE OF FATHER (City) **NOVA SCOTIA**
(State or country)19 MAIDEN NAME OF MOTHER **LOUISE A. ROCK**20 BIRTHPLACE OF MOTHER (City) **EAST BOSTON**
(State or country) **MASS.**21 Informant **LOUISE A McEACHERN**(Address) **36 TAYLOR ST WINTHROP**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:**Paul C. Gaffney (S)**

(Signature of Agent of Board of Health or other)

Director of Public Health June 3, 1965
(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

Nov 18 1940

DATE OF DISCHARGE.....

Dec 25 1945

RANK, RATING.....

Chief Radio Man

ORGANIZATION AND OUTFIT.....

Navy

SERVICE NUMBER.....

460-58-02

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

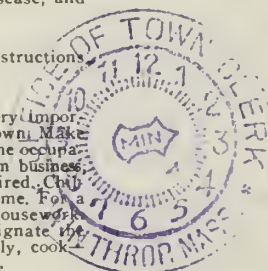
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUSSEX

(County)

1

WINTHROP

(City or Town)

No.

Winthrop Comm Hospital

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

PHYSICIAN — IMPORTANT

2 FULL NAME

Michael D. McGrath

(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) Permanent Residence. No.

35 Lincoln St

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death years months 5 days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 6 1965

Month

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from APRIL 27, 1964 to JUNE 6, 1965

I last saw him alive on JUNE 5, 1965, death is said to have occurred on the date stated above, at 524 A.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF COLON

Due To (b) GENERALIZED METASTASIS 9mo.

Due To (c)

OTHER SIGNIFICANT CONDITIONS

NONE

Was autopsy performed? No

What test confirmed diagnosis? PATHOLOGY REPORT & CLINICAL

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

(Signature) Myron N. King M. D.

(Address) 222 Pleasant St WINTHROP MASS

Date JUNE 6 1965

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL

June 9 1965

7 NAME OF FUNERAL DIRECTOR

Ernest P. Maggiano

ADDRESS

147 Winthrop St Winthrop

Received and filed

JUN 8 - 1965

19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widowed

11 If married, widowed or divorced HUSBAND of

Mary J. Shea

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 67 Years 0 Months 0 Days

If under 24 hours

Hours Minutes

13

Usual Occupation

Carpenter

(Kind of work done during most of working life)

14

Industry or Business

Construction

15

Social Security No.

011-14-8485

16

BIRTHPLACE (City)

Boston mass

(State or country)

17

NAME OF FATHER

Michael M. Grath

18

BIRTHPLACE OF FATHER (City)

Ireland

(State or country)

19

MAIDEN NAME OF MOTHER

Information unavailable

20

BIRTHPLACE OF MOTHER (City)

(State or country)

21

Informant

Eleanor Shea

(Address)

1496 Comm Ave Boston

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

Paul S. Gaffney Jr. 8-1-6

(Signature of Agent of Board of Health or other)

Director of Public Health 6/7/65

(Official Designation)

(Date of Issue of Permit)

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.

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PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 FULL NAME HARRY KAUFMAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No.
(Usual place of abode)

24 CROSS STREET

St. WINTHROP MASS.

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence. 46 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 10, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Feb- 1965, to June 10, 1965I last saw him alive on June 10, 1965 death is said to
have occurred on the date stated above, at 9:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion, Ate 1 hr.

(b) Hypertensive - Coronary 10 yrs

(c) Artery Heart Disease

INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
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(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 6/10/1965

6 Agudos Achim, Melrose
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 11, 1965

7 NAME OF FUNERAL DIRECTOR Torf Funeral Serv., Inc.

ADDRESS 151 Washington Ave., Chelsea

Received and filed JUN 11 1965

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 125

(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) None

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Dona Marden
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 73 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation Manufacturer
(Kind of work done during most of working life)

14 Industry or Business Caps - Oxford Cap Co.

15 Social Security No. 027-28-4664

16 BIRTHPLACE (City). Russia
(State or country)

17 NAME OF FATHER Elizer Kaufman

18 BIRTHPLACE OF FATHER (City). Russia
(State or country)

19 MAIDEN NAME OF MOTHER Edith Feldman

20 BIRTHPLACE OF MOTHER (City). Russia
(State or country)21 Informant Mr. Arthur Kaufman (Son)
24 Orchid Rd., SwampscottI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Galleney
(Signature of Agent of Board of Health or other)
Director of Public Health June 11, 1965
(Official Designation) (Date of Issue of Permit)

Removed 6/15/65

V.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 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.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No.

No. 26 Sturgis St. Bay View Nursing Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

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

(Was deceased a
U. S. War Veteran,
if so specify WAR) **126**

(a) Permanent Residence. No. 50 Pleasant Park Road St.
(Usual place of abode) (City or town and State)

Length of stay: In place of death. years 3 months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 10, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 7, 1965 to June 10, 1965
I last saw h..... alive on June 9, 1965, death is said to
have occurred on the date stated above, at 11 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Cervix uteri

Due To
(b)
Due To
(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

12 mos.

OTHER SIGNIFICANT CONDITIONS Cerebral & generalized arteriosclerosis 2 yrs
Arteriosclerotic heart disease 2 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

(Signature) M. Traunstein, Jr. M. D.
M. Traunstein, Jr. M. D.
(Print or Type Name)
(Address) 73 Bartlett Rd. Date June 11, 1965

6 Calvary Cemetery Waltham
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 14, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass.

Received and filed JUN 14 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Charles E. McDonald
(Husband's name in full)

12 AGE 82 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). Waltham, Mass
(State or country)

17 NAME OF FATHER Cornelius Mahoney

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

19 MAIDEN NAME OF MOTHER Abbie Ahern

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

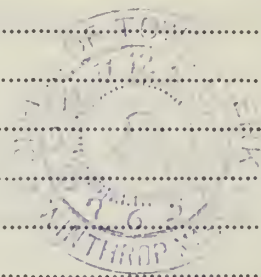
21 Informant Charles E. McDonald
(Address) 50 Pleasant Park Road

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

Paul C. Coffey
(Signature of Agent of Board of Health or other)
Director of Public Health June 14, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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



JUN 1 4 1965 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.

RM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **127**

PLACE OF DEATH

Suffolk (County)
Ninthrop, Mass. (City or Town)



No. *Mayflower Nursing Home* (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME *Leonardo Boccamazza* (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) *10*

(a) Residence. No. *41 Arlington* St. *Chelsea, Mass.* (Usual place of abode) (City or town and State)

Length of stay: In place of death *11* years *11* months *60* days. In place of residence *60* years *11* months *60* days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *JUNE 11 1965*
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from *JUNE 1 1965* to *JUNE 11 1965*

I last saw him alive on *JUNE 11 1965*, death is said to have occurred on the date stated above, at *9:15 P.M.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *GENERALIZED ARTERIO-SCLEROSIS*

Due To *SENILITY*

Due To (c)

OTHER SIGNIFICANT CONDITIONS *HYPERTENSION*

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

(Signature) *MORRIS CLAYMAN M.D.*, M. D.

19-8 CHESTNUT ST. (Print or Type Name)

(Address) *CITELSA 1765* Date *June 12 1965*

6 *St. Michael's Cemetery* (City or Town)
Place of Burial or Cremation *Forest Hills, Boston*

DATE OF BURIAL *June 15, 1965*

7 NAME OF FUNERAL DIRECTOR *Vincent Rapino*

ADDRESS *678 Broadway, Chelsea, Mass.*

Received and filed *JUN 14 1965*

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of *Maria Lomuscio*
(Give maiden name of wife in full)

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

12 AGE *90* Years. Months. Days If under 24 hours
Hours. Minutes

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

14 Industry or Business *Barber Shop*

15 Social Security No. *none*

16 BIRTHPLACE (City) *Italy*
(State or country)

17 NAME OF FATHER *Joseph Boccamazza*

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

19 MAIDEN NAME OF MOTHER *Maria Capaldi*

20 BIRTHPLACE OF MOTHER (City) *Italy*
(State or country)

21 Informant *Louise De Christoforo* (neice)

(Address) *41 Arlington St. Chelsea*

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

Paul C. Goffrey (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation)

June 14 1965 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

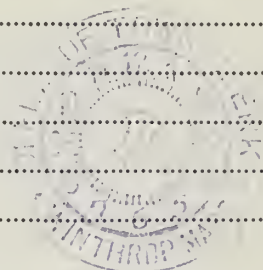
DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



JUN 14 1965 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.

R-303

burial permit
of Health
Agent.

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.

100W-5-611-938000

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**

(City or Town making this return)

Registered No. **128**

No. **Winthrop Community Hospital**

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

2 FULL NAME **M. KATHERINE McDERMOTT**
(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) Permanent Residence. No. **42 Atlantic Street**

(City or town and State)

Length of stay: In place of death.....years.....months.....**7** days. In place of residence **35** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **June 12, 1965**
(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.)

**Fracture of femur.
Arteriosclerotic heart disease.**

5 Accident, suicide, or homicide (specify) **Accident**

Date and hour of injury **May 30, 1965**

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 **Fall from bed to floor.**
(How did injury occur?)

Nature of injury

While at work? **No** 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 **6/12/65**

7 **Holy Cross Malden**
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL **June 15, 1965**

8 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**

ADDRESS **Winthrop Mass**

Received and filed **JUN 14 1965**

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Female** 10 COLOR **White** 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN **Single**

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

13 AGE **80** Year Months Days If under 24 hours
Hours Minutes

14 Usual Occupation: **At Home.**
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. **E Boston Mass**

17 BIRTHPLACE (City) **Boston**
(State or country)

18 NAME OF FATHER **Johnston McDermott**

19 BIRTHPLACE OF FATHER (City) **Boston**
(State or country)

20 MAIDEN NAME OF MOTHER **Mary E Calhoun**

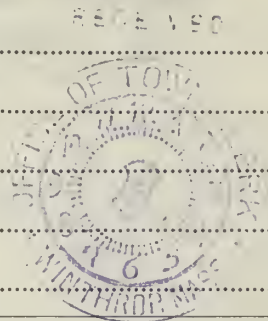
21 BIRTHPLACE OF MOTHER (City) **Boston**
(State or country)

22 Informant **Sylvia McDermott**
(Address) **42 Atlantic St Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death was issued:

Paul C. Gaffney
Director of Public Health **June 14, 1965**
(Official Designation) (Date of Issue of Certificate)

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



RULES OF PRACTICE

JUN 1 1965 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 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.)"

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.)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Reading
(City or Town making this return)

PLACE OF DEATH

Middlesex
(County)

Reading
(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 129

No. Daniel's Nursing Home

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

2 FULL NAME Wendell Albert Hodgkins
(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) Permanent Residence. No. 122 Court Rd.
(Usual place of abode)

Winthrop

(City or town and State)

Length of stay: In place of death.....years.....months.....2.....days. In place of residence.....57.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 13, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
May 3, 1965, to June 13, 1965
I last saw him live on June 13, 1965, death is said to
have occurred on the date stated above, at 10:35 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Congestive Failure

Due To Arteriosclerotic Ht. Dis. 1yr.

Due To Arteriosclerosis 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

(Signature) F. H. Hinnendael M. D.
F. H. Hinnendael M.D.

(Address) Reading Date June 15, 1965

6 Achorn Cemetery, Rockland, Maine
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 17, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop

Received and filed JUN 18 1965

(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
DIVORCED
UNKNOWN

11 If married, widowed or divorced
HUSBAND of Alice Louise Walker
(Give maiden name of wife in full)

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

12 AGE 79 years 8 Months 11 Days
If under 24 hours
Hours Minutes

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

14 Industry or Business Building materials

15 Social Security No. 011-01-0382

16 BIRTHPLACE (City) Bath
(State or country) Maine

17 NAME OF FATHER Albert Weeks Hodgkins

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

19 MAIDEN NAME OF MOTHER Unknown

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

21 Informant Wendell W. Hodgkins
(Address) 248 Pearl St., Reading

A TRUE COPY

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

DATE FILED JUN 15 1965

SPACE FOR ADDITIONAL INFORMATION

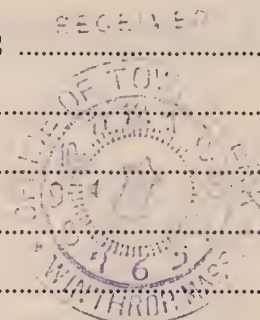
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DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



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The Commonwealth of Massachusetts



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

1 PLACE OF DEATH SUFFOLK
(County)
Winthrop, Mass.
(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No. 130

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. Rose Sibelian (Ferrara) (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) Permanent Residence. No. 42 North Ave., Winthrop, St. Winthrop, Mass. (City or town and State)
(Usual place of abode)

Length of stay: In place of death... years 1 months... days. In place of residence 21 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 13, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from April 1, 1965 to JUNE 13, 1965
I last saw her alive on June 12, 1965 death is said to have occurred on the date stated above, at 1:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Breast.

INTERVAL
BETWEEN
ONSET AND
DEATH
9 mos.

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical, Pathological.

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

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 6/13/65

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 14, 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP

Received and filed JUN 16 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Edward J. Sibelian (Husband's name in full)

12 41 Years 21 Months 21 Days If under 24 hours
AGE 40 Years... Months... Days... Hours... Minutes

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

14 Industry or Business HOME

15 Social Security No. 021-14-7372

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

17 NAME OF FATHER Vincent Ferrara

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

19 MAIDEN NAME OF MOTHER D'Amore, Angelina

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

21 Informant EDWARD J. SIBELIAN
(Address) 42 NORTH AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Paul C. Gallwey (Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) June 16 1965 (Date of Issue of Permit)

V.B.

41- 7-21- MR. S. I. beliax
telephoned

JUN 18 1965

SPACE FOR ADDITIONAL

DATE OF ENTERING MILITARY

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.

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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Medical Examiner Notified - Referred to Board of Health

Medical Examiner Notified - Referred to Board of Health

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

Suffolk
(County)

Winthrop
(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No. 131

No. 375 Revere St.

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

2 FULL NAME Catherine M. 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) No

(a) Residence. No. 375 Revere St.
(Usual place of abode)

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

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 15, 1965
(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 7:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death - presumably

Due To due to natural

(b) causes.

Due To Winthrop Board of Health

(c) Charles Liberman M.D.

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

(Signature) Charles Liberman, M. D.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP, MASS Date 6/15/1965

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

DATE OF BURIAL June 18, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JUN 16 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of George F Griffin
(Husband's name in full)

12 AGE 66 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

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

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Ireland
(State or country)

17 NAME OF FATHER Timothy Sheehan

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

19 MAIDEN NAME OF MOTHER Mary Clifford

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

21 Informant George F. Griffin
(Address) 375 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:

Paul C. Gaffney Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health June 16, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

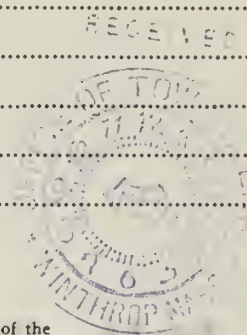
DATE OF DISCHARGE

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.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **132**

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

No. **263 MAIN ST**

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

PHYSICIAN - IMPORTANT

2 FULL NAME **MARY (DOYLE) BROCK**
(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) Permanent Residence. No. **263 MAIN ST**
(Usual place of abode)

St. **WINTHROP**
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **June 17 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
April 6, 19**1960**, to **June 17**, 19**65**
I last saw **her** alive on **June 15**, 19**65**, death is said to
have occurred on the date stated above, at **11:15 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Terminal pneumonia**

(b) **Chronic myeloiditis**

(c) **Carcinoma Breast**

INTERVAL
BETWEEN
ONSET AND
DEATH
2 1/2 yrs
4 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? **no**

What test confirmed diagnosis **Path. Report from Mass General**

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

(Signature) **Louis E. Schaffner M.D.**, M. D.
Louis E. Schaffner M.D.
(Print or Type Name)
(Address) **19 Bennington St** Date **June 17 1965**

6 **WINTHROP** **WINTHROP**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **JUNE 21** 19**65**

7 NAME OF FUNERAL DIRECTOR **MAURIE W. NIXON**

ADDRESS **WINTHROP**
JUN 18 1965

Received and filed19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of **OLIVER J. BROCK**
(Husband's name in full)

12 **03** AGES **03** Years..... Months..... Days
If under 24 hours
..... Hours..... Minutes

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

14 Industry or Business **RESTAURANT**

15 Social Security No.

16 BIRTHPLACE (City) **IRELAND**
(State or country)

17 NAME OF FATHER **PATRICK DOYLE**

18 BIRTHPLACE OF FATHER (City) **IRELAND**
(State or country)

19 MAIDEN NAME OF MOTHER **MARGARET BURNS**

20 BIRTHPLACE OF MOTHER (City) **IRELAND**
(State or country)

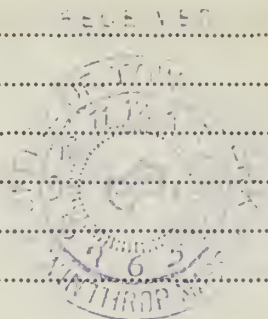
21 Informant **WALTER BROCK**
(Address) **263 MAIN ST WINTHROP**

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

Paul C. Goffney (a)
(Signature of Agent of Board of Health or other)
Director of Public Health (June 18, 1965)
(Official Designation) (Date of Issue of Permit)

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

JUN 18 1965 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.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **133**

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 Mr. James W. Tallent
(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) Permanent Residence. No. 150 Circuit Rd. St. Winthrop, Mass.
(Usual place of abode) (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 JUNE 17, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from MARCH 27, 1965, to JUNE 16, 1965.

I last saw him alive on JUNE 16, 1965, death is said to have occurred on the date stated above, at 5:45 am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION 5 MIN.

Due To RHEUMATIC HEART DIS

(b) + ARTERIOSCLEROTIC HEART DIS
(c) + AURICULAR FIBRILLATION

OTHER SIGNIFICANT CONDITIONS RUPTURED DISC. 2 YRS.
HEPATIC RT INGUINAL

Was autopsy performed? No. Inguinal

What test confirmed diagnosis? CLINICAL

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

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.

(Address) 222 Pleasant St. Date JUNE 17, 1965
WINTHROP

6 WINTHROP, WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 19, 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. HIRBY

ADDRESS WINTHROP

Received and filed JUN 18 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED
MARRIED WIDOWED UNKNOWN

11 If married, widowed, or divorced HUSBAND of CATHERINE C. McBRIDE
(Give maiden name of wife in full)

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

12 AGE 66 Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business DAIRY

15 Social Security No. 014-15-6043

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

17 NAME OF FATHER WILLIAM TALLENT

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

19 MAIDEN NAME OF MOTHER MARY DOYLE

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

21 Informant CATHERINE TALLENT

(Address) 150 CIRCUIT RD WINTHROP

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

Paul C. Giffney (S)

(Signature of Agent of Board of Health or other)

Director of Public Health June 18, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

MARCH 24 1917

DATE OF DISCHARGE.....

JUNE 26 1919

RANK, RATING

GUNNERS MATE 3RD CLASS

ORGANIZATION AND OUTFIT.....

NAVY

SERVICE NUMBER.....

103-45-38

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 18 1919 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

FORM R-301

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No.

WINTHROP COMMUNITY HOSPITAL

STANDARD

CERTIFICATE OF DEATH

Registered No.

134

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

PHYSICIAN — IMPORTANT

EDUCATION
FOR
MEDICAL CERTIFICATE

2 FULL NAME

Charles E. Woods

(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) Permanent Residence. No. (Usual place of abode)

2 Burrill Terrace

St. Winthrop, Mass

(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 June 22 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from *May* 1962, to *June 22* 1965

I last saw *alive* on *June 21* 1965, death is said to have occurred on the date stated above, at *11:45 A.M.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Bronchopneumonia Terminal*

Due To (b) *Cerebral vascular*

hemorrhage

Due To (c) *arterio-sclerosis-gen*

myocardial Heart Disease

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

(Signature) *Joseph Greigore*, M. D.

(Print or Type Name)

(Address) *Wilmington* Date *6-22* 1965

6 WINTHROP WINTHROP

Place of Burial or Cremation (City or Town)

DATE OF BURIAL *JUNE 25* 1965

7 NAME OF FUNERAL DIRECTOR *MAURICE W KIRBY*

ADDRESS *WINTHROP*

Received and filed *JUN 24 1965*

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *MALE* 9 COLOR *WHITE* 10 SINGLE (write the word) *MARRIED*
WIDOWED
DIVORCED
UNKNOWN *WIDOWED*

11 If married, widowed, or divorced HUSBAND of *ROTH E DYER*
(Give maiden name of wife in full)

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

12 AGE *81* Years.....Months.....Days If under 24 hours
Hours.....Minutes

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

14 Industry or Business *P.R.*

15 Social Security No.....

16 BIRTHPLACE (City) *MONTREAL*
(State or country) *CAN*

17 NAME OF FATHER *CHARLES E WOODS*
ELMER DANIALS

18 BIRTHPLACE OF FATHER (City) *PLYMOUTH*
(State or country) *MASS*

19 MAIDEN NAME OF MOTHER *ELIZABETH*
THOMAS

20 BIRTHPLACE OF MOTHER (City) *IRELAND*
(State or country)

21 Informant *CHARLES E WOODS*

(Address) *2 BURRILL TERRACE WINTHROP*

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

Paul C. Giffney (Signature of Agent of Board of Health or other)

Director of Public Health June 24 1965

(Official Designation) (Date of Issue of Permit)

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.

RECEIVED



JUN 24 1965 AM

FORM R-301

Suffolk

(County)

Winthrop

(City or Town)

No. 10 Willis Ave

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
 CERTIFICATE OF DEATH

Registered No. 135

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

PHYSICIAN — IMPORTANT

2 FULL NAME William J. Barrett
 (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) Permanent Residence. No. 10 Willis Ave
 (Usual place of abode) St. (City or town and State)

Length of stay: In place of death 5 years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 23, 1965
 (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 9:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably

(b) Due To due to natural causes

(c) Due To Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman, M.D.

Was autopsy performed? No

What test confirmed diagnosis?

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

(Signature) Charles Liberman, M.D.

(Print or Type Name) CHARLES LIBERMAN

(Address) Winthrop, Mass. Date 6/24/1965

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

DATE OF BURIAL June 26, 1965 19

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed JUN 25 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Divorced UNKNOWN Married

11 If married, widowed, or divorced
 HUSBAND of Marion H. Almeda
 (Give maiden name of wife in full)

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

12 AGE 71 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 School Supplies

15 Social Security No. 028-05-5028

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

17 NAME OF FATHER William J. Barrett

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

19 MAIDEN NAME OF MOTHER Norah Callahan

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

21 Informant Marion Barrett

(Address) 10 Willis Ave Winthrop

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

Paul C. Gaffney (B)
 (Signature of Agent of Board of Health or other)

Director of Public Health June 25, 1965
 (Official Designation) (Date of Issue of Permit)

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:

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **136**

(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**

Suffolk
(County)

Winthrop
(City or Town)

No. **Bay View Nursing Home**

2 FULL NAME **Hans Carl Kleemann**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. **92 Quincy Avenue** St. **Winthrop**
(Usual place of abode) (City or town and State)

Length of stay: In place of death **3** years **6** months **0** days. In place of residence **50** years **0** months **0** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **June 26 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Aug. 1958 to **June 26 1965**

I last saw **alive** on **June 26 1965**, death is said to
have occurred on the date stated above, at **2:00 P. M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Hypertensive - Arterio - 5 yrs**
(b) **sclerotic Heart Disease**

Due To
(c)

OTHER SIGNIFICANT CONDITIONS **Osteomyelitis Jaw 1 yr.**
Permanent Polystomy Bojrs

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

(Signature) **Charles Liberman** M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) **WINTHROP, MASS 01890**

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

DATE OF BURIAL **June 30 1965**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St. Winthrop,**

Received and filed **JUN 29 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED **widowed**

11 If married, widowed, or divorced
HUSBAND of **Anna Charlotte Puxseman**
(Give maiden name of wife in full)

(or) WIFE of **Anna Charlotte Puxseman**
(Husband's name in full)

12 AGE **76** Years **7** Months **27** Days **27** Hours **0** Minutes
If under 24 hours

13 Usual Occupation **retired salesman**
(Kind of work done during most of working life)

14 Industry or Business **Retail Shoe Mfg. Co.**

15 Social Security No. **065-03-1132**

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

17 NAME OF FATHER **Carl Kleemann**

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

19 MAIDEN NAME OF MOTHER **Johanna Rhode**

20 BIRTHPLACE OF MOTHER (City) **Germany**
(State or country)

21 Informant **Harold C. Kleemann**
3237
(Address) **Roosevelt Dr. Dearborn, Mich.**

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

Paul C. Gaffney Jr.
(Signature of Agent of Board of Health or other)
Director of Public Health June 29 '65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



JUN 29 1965 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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 137

Suffolk
(County)
Winthrop
(City or Town)

No. 95 Bowdoin Street

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

PHYSICIAN — IMPORTANT

2 FULL NAME Anhia Calista Hall (Smith)
(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) Permanent Residence. No. 95 Bowdoin Street
(Usual place of abode)

(City or town and State)

Length of stay: In place of death 41 years.....months.....days. In place of residence 41 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 28 1965
(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 9:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due to natural causes.

(b) Winthrop Board of Health

(c) Charles Liberman, M.D.

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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 6/28/65

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

DATE OF BURIAL July 1 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed JUN 29 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Warren Cudworth Hall
(Husband's name in full)

12 AGE 76 Years 5 Month 25 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. 027-07-6453-A

16 BIRTHPLACE (City). Somerville
(State or country) Massachusetts

17 NAME OF FATHER Stephen Smith

18 BIRTHPLACE OF FATHER (City). Rhode Island
(State or country)

19 MAIDEN NAME OF MOTHER Fannie Curtis

20 BIRTHPLACE OF MOTHER (City). Addison
(State or country) Maine

21 Informant Mrs. George S. Gibbey

(Address) P.O. Box 96, W. Topsham, VT.

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

Paul C. Gaffney, Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health
(Official Designation) (Date of Issue of Permit) 6/29/65

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....RECEIVED.....



JUN 29 1965 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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. **138**

nd for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
OF DEATH

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

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

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

nditions contrib-
o death but not
to the terminal
condition given

BB

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 590 SHIRLEY ST

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

PHYSICIAN — IMPORTANT

2 FULL NAME WILLIAM B THOMAS
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) **WVI**(a) Permanent Residence, No. 590 SHIRLEY
(Usual place of abode)St. WINTHROP
(City or town and State)

Length of stay: In place of death 56 years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 30, 1965
(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 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due To natural causes.

(c) Due To Winthrop Board of Health

OTHER
SIGNIFICANT
CONDITIONS

Charles Liberman M.D.

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/1/1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 2 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed JUL 1 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

12 AGE 67 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation LABORER
(Kind of work done during most of working life)

14 Industry or Business GENERAL

15 Social Security No.

16 BIRTHPLACE (City) EVERETT
(State or country) MASS

17 NAME OF FATHER MICHAEL THOMAS

18 BIRTHPLACE OF FATHER (City) MONTREAL
(State or country) CAN.

19 MAIDEN NAME OF MOTHER ELIZABETH DEMSEY

20 BIRTHPLACE OF MOTHER (City) ARLINGTON
(State or country) MASS

21 Informant MRS SUSAN LINDSEY

(Address) 56 FAIRVIEW ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Goffney (P)
(Signature of Agent of Board of Health or other)Director of Public Health July 1, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE NOV 12 1917

DATE OF DISCHARGE DEC 27 1918

RANK, RATING DEC 27 1918 PRIVATE

ORGANIZATION AND OUTFIT ARMY

SERVICE NUMBER 1226716

RECEIVED



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 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.

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.)

25M-3-61-930213

PLACE OF DEATH

Essex

(County) Danvers

(City or Town)

Danvers State Hospital

No.

Minnie Fountain (Hiscock)

2 FULL NAME

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

(a) Residence. No.

(Usual place of abode)

St.

Winthrop, Mass/

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....6 months.....16 days. In place of residence.....years.....months.....days.

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or town making return)

Registered No.

139

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 18 1965
(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 thrombosis
with sudden death

NO

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?

(Specify type of place)

Manner of

injury

(How did injury occur?)

Nature of injury

NO

NO

While at work? Was autopsy performed?

NO

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

If so, specify

Arthur W. O'Neil

(Signed)

Arthur W. O'Neil

M. D.

(Address)

Saalm, Mass

Date

4-18-65

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

DATE OF BURIAL

April 21

19

65

8 NAME OF FUNERAL DIRECTOR

Maurice W. Kirby

ADDRESS

Winthrop, Mass

Received and filed

4-23

19

65

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR white 11 CITIZEN OF U.S. YES ☐ NO ☐ 12 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

12a If married, widowed, or divorced

HUSBAND of

John V. Fountain

(Husband's name in full)

(or) WIFE of

(Husband's name in full)

13 DATE OF BIRTH

7-3

27

14

AGE

Years

Months

Days

Hours

Minutes

Retired Domestic

15 Usual

Occupation:

(Kind of work done during most of working life)

16 Industry

or Business:

0-266-46-2896

Newfoundland

17 Social Security No.

Canada

18 BIRTHPLACE (City)

(State or country)

James Hiscock

19 NAME OF

FATHER

Newfoundland

Canada

20 BIRTHPLACE OF

FATHER (City)

(State or country)

Katherine Skanes

21 MAIDEN NAME

OF MOTHER

Newfoundland

22 BIRTHPLACE OF

MOTHER (City)

(State or country)

Canada

Helen A. Ziolkowski

23

Informant

(Address)

Danvers, Mass.

A TRUE COPY.

ATTEST:

Tracy I. Flagg

(Registrar of City or Town where death occurred)

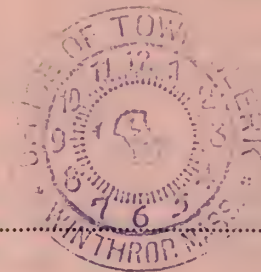
DATE FILED

Public Health

April 18, 1965

X

REC'D 1965



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE JUL 9 1965 AM

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.)

100N-5-61-938000

PLACE OF DEATH		The Commonwealth of Massachusetts		Danvers	
Essex (County) Danvers (City or Town)		 KEVIN H. WHITE SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS		Danvers (City or Town making this return)	
COPY OF CERTIFICATE OF DEATH				Registered No. 140	
No. Danvers State Hos.				{(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)	
2 FULL NAME Flora Jeanette Sampson					
(If deceased is a married, widowed or divorced woman, give also maiden name.)					
(a) Permanent residence. No. 10 Ocean Ave. St. Winthrop, Mass.					
(City or town and State)					
Length of stay: In place of death 21 years 6 months 26 days. In place of residence.....years.....months.....days.					
MEDICAL CERTIFICATE OF DEATH			PERSONAL AND STATISTICAL PARTICULARS		
3 DATE OF DEATH May 21, 1965			8 SEX female		
(Month) (Day) (Year)			9 COLOR black		
4 PERMANENT CERTIFICATE. The I attended deceased from April 30, 1961 to May 21, 1965			10 SINGLE (write the word) single MARRIED WIDOWED DIVORCED UNKNOWN		
I last saw him alive on May 21, 1965 at 1:30 p.m. death is said to have occurred on the date stated above, at 1:30 p.m.			11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)		
DEATH WAS CAUSED BY IMMEDIATE CAUSE			(or) WIFE of (Husband's name in full)		
(a) rupture of myocardium with myocardial infarction of poster ventricle			12 AGE 52 Years 6 Months 5 Days		
(b) occlusion of right coronary artery			If under 24 hoursHours.....Minutes		
(c) diabetes mellitus			13 Usual Occupation: Laundry Worker (Kind of work done during most of working life)		
OTHER SIGNIFICANT CONDITIONS healed pyelonephritis			14 Industry or Business:		
Was autopsy performed? Autopsy			15 Social Security No. not determined		
What test confirmed diagnosis? Autopsy			16 BIRTHPLACE (City) Melfose, Mass. (State or country)		
5 Was disease or injury in any way related to occupation of deceased?			17 NAME OF FATHER George Sampson		
If so, specify			18 BIRTHPLACE OF FATHER (City) New York (State or country)		
(Signature) Willard M. Hausman			19 MAIDEN NAME OF MOTHER Mary Walker		
(Address) Danvers, Mass. Date 5-21-65			20 BIRTHPLACE OF MOTHER (City) Kentucky (State or country)		
Wyoming Cem. Melrose, Mass.			21 Informant Helen A Ziolkowski		
6 Place of Burial or Cremation (City or Town)			(Address) Danvers, Mass.		
DATE OF BURIAL May 26, 1965			A TRUE COPY		
7 NAME OF FUNERAL DIRECTOR Bland Funeral Home			ATTEST: Tracy I. Flagg		
ADDRESS Cambridge, Mass.			(Registrar of City or Town where death occurred)		
Received and filed May 27, 1965			Health Agent. May 21, 1965		
(Registrar of City or Town where deceased resided)			DATE FILED19.....		

X

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

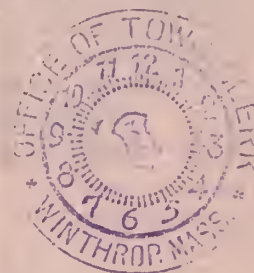
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

RECEIVED



JUL - 9 1965 AM

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-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.)

25M-4-59-925100

PLACE OF DEATH

1

ESSEX

(County)

LAWRENCE

(City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITESECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

LAWRENCE

(City or town making return)

COPY OF

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No.

596

111

Lawrence General Hospital

No.

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

2 FULL NAME

Alfred L. Ginepra

(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.

135 Main

(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 - years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

June 13, 1965

(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.)

Fracture Skull with Epidural
Hemorrhage Hemophysis due to
Contusion Lung.

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 7 P.M. 6/13 19 65

If accidental, was injury causally related to the death? Yes

Where did
Injury occur?

Andover

(City or town and State)

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

(Specify type of place)

Manner of
Injury

Engine toppled over

(How did injury occur?)

Nature of
Injury

As Above

While at work? Yes Was autopsy performed? No

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

If so, specify

(Signed) John T. Batal

M. D.

(Address) Lawrence, Mass. Date 6/14 19 65

7 Old Calvary Cem. Boston, Mass.

Place of Burial, or Cremation.

(City or Town)

DATE OF BURIAL

June 17, 19 65

8 NAME OF
FUNERAL DIRECTOR

Arthur O'Maley

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
or DIVORCED

Married

11a If married, widowed, or divorced

HUSBAND of

Ruth Burns

(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:

Engineer

(Kind of work done during most of working life)

15 Industry

or Business:

Railroad

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

Boston, Mass.

18 NAME OF
FATHER

Charles D. Ginepra

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

20 MAIDEN NAME

OF MOTHER

Lida E. Vanni

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

22

Informant
(Address)

A. Ruth Ginepra

135 Main St., Winthrop, Mass.

A TRUE COPY.

ATTEST:

(Registrar of City or Town where death occurred)

June 17, 19 65

DATE FILED

Removed from Old Vol. Bk.

V.B.

RECEIVED



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE JUL - 9 1965 AM

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.)

100M-5-64L-938000

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 142

No. Danvers State Hos.

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

2 FULL NAME Evelyn Steed (Evelyn Coombs)

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

{(Was deceased a U. S. War Veteran, if so specify WAR) n0

(a) Permanent residence. No. 54 Belcher St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, 1 years, 5 months, 4 days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 24, 1965

(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from Jan. 20 to June 24, 1965

I last saw him alive on June 24, 1965 death is said to have occurred on the date stated above, at 8:45 am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Bronchopneumonia

(a) Due To arteriosclerotic ht dis. yrs

(c) Due To gen. arteriosclerosis yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? Clin & Lab.

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

(Signature) Willard M. Hausman M. D.

(Address) Danvers, Mass. 6-24-65

6 Winthrop Cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 26, 1965

7 NAME OF FUNERAL DIRECTOR Kirby Funeral Home Winthrop, Mass.

ADDRESS

Received and filed June 28, 1965
J. H. Clark
(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 DIVORCED UNKNOWN widowed

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Florence J. Steed (Husband's name in full)

12 AGE 71 Years 5 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:

15 Social Security No. not determined

16 BIRTHPLACE (City) Cambridge, Mass. (State or country)

17 NAME OF FATHER J. Elias Coombs

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

19 MAIDEN NAME OF MOTHER Jennie Pineo

20 BIRTHPLACE OF MOTHER (City) King's County (State or country) Canada

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

Tracy I. Flagg
Health Agent. (Registrar of City or Town where death occurred)

DATE FILED June 24, 1965

M. H. 1965- (Alice E.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



JUL 29 1965 AM

JUL 29 1965 AM

JUL 29 1965 AM

Cambridge

(City or Town making this return)

898 143

Registered No.

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH



Middlesex

(County)

Cambridge

(City or Town)

PLACE OF DEATH

1

Cambridge City Hospital

No.

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

2 FULL NAME Douglas R. Mansfield

(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)

69 Undine Avenue

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 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 27, 1965

(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.)

Fr. Skull

Cerebral lacerations

Multiple injuries.

Accident

5 Accident, suicide, or homicide (specify) 1: P.M. 6-23 65

Date and hour of injury 19..... Yes

IF ACCIDENTAL, was injury causally related to the death? Yes

Where did injury occur? Cambridge, Mass.

(City or town and State)

Did injury occur in a home, in industrial place, or in
public place? Public place

Manner of injury Prospect & Harvard St.

Nature of injury Collision 2 cars

While at work? no Was autopsy performed? yes

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

If so, specify Andrew D. Guthrie

(Signed) M. D.

(Address) Medford, Mass. 6-27 65

7 Place of Burial or Cremation. Edson Cem. Lowell

DATE OF BURIAL June 30, 1965

8 NAME OF FUNERAL DIRECTOR Horace E. Fyle

ADDRESS 90 Westford St. Lowell

Received and filed JUL 14 1965

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

Male

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Married

12 If married, widowed, divorced, or single
HUSBAND of Silvia M. Nowitsch

(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)13 AGE 26 Years 1 Months 4 Days If under 24 hours
Hours Minutes14 Usual Occupation: body repair man
(Kind of work done during most of working life)

15 Industry or Business: self employed

013-30-1289

16 Social Security No. Lowell

17 BIRTHPLACE (City) Mass.

(State or country)

18 NAME OF FATHER William S. Mansfield

19 BIRTHPLACE OF FATHER (City) Lowell

(State or country) Mass.

20 MAIDEN NAME OF MOTHER Elizabeth M. Terham

21 BIRTHPLACE OF MOTHER (City) Lowell

(State or country) Mass.

22 Informant (Address) Mrs. Douglass R. Mansfield

69 Undine Ave. Winthrop, Mass.

A TRUE COPY

ATTEST: Thomas M. Damara
(Registrar of City or Town where death occurred)

DATE FILED June 28, 1965

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-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.)

SOM-3-62-932695

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RECEIVED



JUL 14 1965 AM

nd for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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, (b) and (c)

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

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

nditions contrib-
o death but not
to the terminal
condition given

BB

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

144

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

PHYSICIAN — IMPORTANT

2 FULL NAME Ernest Key

(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) Permanent Residence. No.

332 Pleasant Street, Winthrop, Mass.

(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 1 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
June 29, 19. 65, to July 1, 19. 65I last saw him alive on July 1, 1965, death is said to
have occurred on the date stated above, at 2:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolus

Due To (b) Postoperative Prostatectomy

Due To (c)

OTHER SIGNIFICANT CONDITIONS Coronary Artery Disease

INTERVAL
BETWEEN
ONSET AND
DEATH

10 Min. 28 hrs.

Over 5 yrs.

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

(Signature) John F. Collins, M. D.

(Print or Type Name)

(Address) 27 Bennington St., Revere, Mass. Date July 2, 1965

6 Old North Cemetery Weymouth

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 3 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed JUL 2 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Edith Burrell
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 80 Years 4 Months 27 Days If under 24 hours
Hours Minutes13 Usual Occupation Purchasing Agent
(Kind of work done during most of working life)

14 Industry or Business Steamship Co

15 Social Security No. 030-20-9715

16 BIRTHPLACE (City) England
(State or country)

17 NAME OF FATHER William S Key

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

19 MAIDEN NAME OF MOTHER Rose Hopewell

20 BIRTHPLACE OF MOTHER (City) England
(State or country)21 Informant Edith Key
(Address) 332 Pleasant St. Winthrop, MassI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Goffney (B)
(Signature of Agent of Board of Health or other)
Director of Public Health July 2, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY. ATTEST:

RECEIVED

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



JUL 2 1965 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.

ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

hist
Henry J.

NT OR TYPE
E OR CAUSES
F DEATH

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, (b) and (c)

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

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

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

B.B.

Medical Examiner Notified - Refer to Board of Health

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

No. 96 LORING RD.

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

(a) Permanent Residence. No. 96 LORING RD.
(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
(City or town and State)

Length of stay: In place of death 52 years.....months.....days. In place of residence 52 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 3, 1965
(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 11:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
to natural causes

(b) Due To Wintthrop Board of Health

(c) OTHER SIGNIFICANT CONDITIONS
Charles Liberman, MD

Was autopsy performed?

What test confirmed diagnosis?

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

(Signature) Charles Liberman, M.D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date July 5, 1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 6, 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed JUL 6 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No.

145

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED

11 If married, widowed, or divorced
HUSBAND of ALICE E. DAILY
(Give maiden name of wife in full)

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

12 AGE 83 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 INSURANCE

15 Social Security No.

16 BIRTHPLACE (City) BROOKLINE
(State or country) MASS.

17 NAME OF FATHER BERNARD DWYER

18 BIRTHPLACE OF FATHER (City) BROOKLINE
(State or country) MASS.

19 MAIDEN NAME OF MOTHER SARAH (UNKNOWN)

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

21 Informant MRS ALICE (DAIZY) DWYER

(Address) 96 LORING 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:

Paul C. Goffney (Signature of Agent of Board of Health or other)

Director of Public Health July 6, 1965
(Official Designation) (Date of Issue of Permit)

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

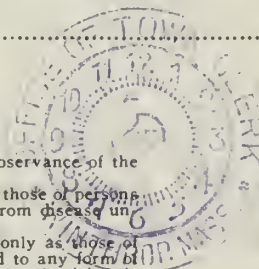
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths 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



SEP 6 1965 AM

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

IT OR TYPE
OR CAUSES
OF DEATH

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

h 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.

nditions contrib-
o death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

PLACE OF DEATH

1

Suffolk
(County)
Winthrop
(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 146

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

2 FULL NAME Lenora G. (Hubbard) Grant
(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. 115 Addison St. Chelsea, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 5th 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN 5, 1965 to July 5, 1965

I last saw her alive on July 2, 1965 death is said to
have occurred on the date stated above, at 3:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) UREMIA
Interval between ONSET AND DEATH 4 days

Due To CHRONIC Nephritis
(b) 20 YRS.

Due To Congenital Heart
(c)

OTHER SIGNIFICANT CONDITIONS Heart failure
PARKINSON'S Disease

Was autopsy performed? no

What test confirmed diagnosis?

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

(Signature) G. Guy Grande, M. D.

(Address) 20 SARATOGA ST EAST, BOSTON 7/6 1965

6 Silver Lake Cemetery, Bucksport, Maine
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 7, 1965

7 NAME OF FUNERAL DIRECTOR Edmund Loarafa

ADDRESS 389 Washington Ave Chelsea

Received and filed JUL 7 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of Louis
(Give maiden name of wife in full)
(or) WIFE of Louis Grant
(Husband's name in full)

12 AGE 88 Years 10 Months 20 Days If under 24 hours Hours Minutes

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

14 Industry or Business Banking

15 Social Security No. 023-05-2656

16 BIRTHPLACE (City) Bucksport, Maine
(State or country)

17 NAME OF FATHER William Hubbard

18 BIRTHPLACE OF FATHER (City) Bucksport, Maine
(State or country)

19 MAIDEN NAME OF MOTHER Elizabeth Turner

20 BIRTHPLACE OF MOTHER (City) Bucksport, Maine
(State or country)

21 Informant Anna Hubbard
(Address) 115 Addison St. Chelsea, Mass.

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

Paul C. Goffney
(Signature of Agent of Board of Health or other)
Director of Public Health July 6, 1965
(Official Designation) (Date of Issue of Permit)

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.

FORM R-301

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
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se for each
, (b) and (c)

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

titions, if any,
h gave rise to
e cause (a),
ng the under-
g cause last.

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

PLACE OF DEATH

SUFFOLK

(County)

Winthrop

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 147

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

2 FULL NAME Anderson Mary (Doyle)
(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 Grove St. 11 Summit 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... years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 8 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
July 1960, to July 8, 1965.

I last saw her alive on July 18, 1965, death is said to
have occurred on the date stated above, at 3:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart 3 yrs.
Due To Disease.

(b) Due To Cerebral Arteriosclerosis 6 mos.

(c) OTHER SIGNIFICANT CONDITIONS Hypochromic Anemia 2 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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/8/1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 12 1965

7 NAME OF FUNERAL DIRECTOR Ernest Baylance

ADDRESS 147 Winthrop St Winthrop

Received and filed JUL 12 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Philip L ANDERSON
(Husband's name in full)

12 AGE 84 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most 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 James Doyle

18 BIRTHPLACE OF FATHER (City) Philadelphia
(State or country) Pa.

19 MAIDEN NAME OF MOTHER Nora D Connor

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

21 Informant Philip L Anderson-Sr
(Address) 6 Smith Way Higham Mass

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

Paul C. Sullivan (M.D.)
(Signature of Agent of Board of Health or other)

Director of Public Health 7/11/65
(Official Designation) (Date of Issue of Permit)

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.

RECEIVED



JUL 12 1965 PM

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
DEATH CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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

does not mean
cause 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-
to death but not
to the terminal
condition given

B.B.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 148

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 Mr. William Mahoney (If deceased was married, widowed or divorced, give also maiden name.)

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

(a) Permanent Residence. No. 827 Shirley St. Winthrop, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death, years, months, 40 days. In place of residence, 20 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 8, 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Oct. 23, 1964, to July 8, 1965. I last saw him alive on July 8, 1965, death is said to have occurred on the date stated above, at 11:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA LEFT LUNG WITH METASTASES 10 MOS

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS GENERALIZED ARTERIOSCLEROSIS 2 YRS

Was 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

(Signature) M. Traunstein Jr. M. D.

M. TRAUNSTEIN, JR. M.D.
(Print or Type Name)

(Address) 73 BARTLETT RD. WINTHROP, MASS. Date: JULY 8, 1965

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

DATE OF BURIAL July 12, 1965

7 NAME OF FUNERAL DIRECTOR J.F. McGLINCHEY FUNERAL HOME
By RICHARD F NORTON

ADDRESS 583 BROADWAY, CHELSEA.

Received and filed JUL 9 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced HUSBAND of Mary E. Kiniry (Give maiden name of wife in full)

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

12 AGE 71 Years, Months, Days If under 24 hours Hours, Minutes

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

14 Industry or Business Retired

15 Social Security No.

16 BIRTHPLACE (City) Charlestown (State or country)

17 NAME OF FATHER James L Mahoney

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

19 MAIDEN NAME OF MOTHER Mary Henderson

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

21 Informant William F Mahoney

INC. 827 Shirley, Street (Address)

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

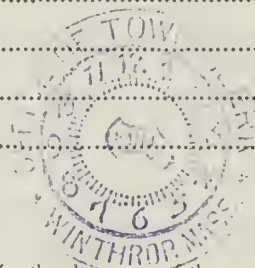
Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) 7/9/65 (Date of Issue of Permit)

A TRUE COPY ATTEST:

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~~ 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 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.

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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

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

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

nditions contrib-
o death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)
WINTHROP, MASS.

(City or Town)

WINTHROP COMMUNITY HOSPITAL

STANDARD

CERTIFICATE OF DEATH

Registered No.

149

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

PHYSICIAN — IMPORTANT

No.

MARIE (FIX) CUMMINGS

2 FULL 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) Permanent Residence. No.

6010 SHIRLEY ST. WINTHROP St.

(Usual place of abode)

(City or town and State)

Length of stay: In place of death, years, months, 66 days. In place of residence, 25 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 9 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
5/4/65, 19, to July 9, 1965
I last saw h. alive on July 9, 1965, death is said to
have occurred on the date stated above, at 11:18 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular hemorrhage
(b) arteriosclerosis
(c) genINTERVAL
BETWEEN
ONSET AND
DEATH

2 hr

yr

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

(Signature) Joseph P. Spagnoli, M. D.

(Print or Type Name) Joseph P. Spagnoli
(Address) 194 Washington Ave. Date 7-9-19656 NEW CALVARY BOSTON
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 12 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY

ADDRESS WINTHROP

Received and filed JUL 12 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED widowed
DIVORCED
UNKNOWN MARRIED11 If married, widowed, or divorced
HUSBAND of JOHN E. CUMMINGS
(Give maiden name of wife in full)
(or) WIFE of JENNIE CUMMINGS
(Husband's name in full)12 AGE 71 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 CUMMINGS

15 Social Security No. 034-209142

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

17 NAME OF FATHER JOSEPH W. FIX

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS

19 MAIDEN NAME OF MOTHER ELIZABETH BAKER

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS

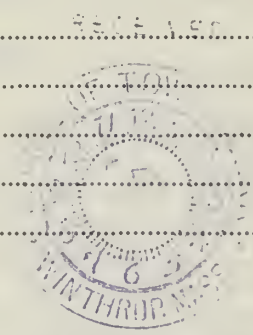
21 Informant MRS. ELIZABETH NOYES

(Address) 43 FREMONT ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Gaffney (M.D.)
(Signature of Agent of Board of Health or other)
Director of Public Health
(Official Designation)

(Date of Issue of Permit) 7/12/65

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

FORM R-301

ed for burial permit
Board of Health
r its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

not enter
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se for each
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does not mean
ode of dying,
s heart failure,
1, 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-
o death but nat-
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 153 Court Road



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 150

{(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) **W W I**

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

153 Court Road

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

Length of stay: In place of death 35 years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 10, 1965
(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 5:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
to natural causes

(b) probably due to an

(c) acute coronary occlusion

OTHER SIGNIFICANT CONDITIONS
on basis of history
Winthrop Board of Health
Charles Liberman, M.D.

Was autopsy performed? NO

What test confirmed diagnosis? **Q**

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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP Date 7/10/1965

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

DATE OF BURIAL July 13, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUL 12 1965 19____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced
HUSBAND of Claire Bulger
(Give maiden name of wife in full)

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

12 AGE 72 Years.....Months.....Days If under 24 hours
Hours.....Minutes

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

14 Industry or Business: Suffolk Superior Court

15 Social Security No. _____

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

17 NAME OF FATHER Henry Kiley

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

19 MAIDEN NAME OF MOTHER Phoebe Tibbetts

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

21 Informant Claire B. Kiley
(Address) 153 Court Road, Winthrop

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

Paul C. Gaffney, M.D.
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) 7/12/65 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

11-27-17

DATE OF DISCHARGE.....

9-30-21

RANK, RATING

ENSIGN

ORGANIZATION AND OUTFIT.....

U. S. N. T. F

SERVICE NUMBER.....

102-50-09

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.

RECEIVED



JUL 12 1965 PM

ed for burial permit
Board of Health
r its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
E OR CAUSES
7 DEATH

not enter
re than one
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does not mean
ode of dying,
s heart failure,
2, etc. It means
case, or compli-
which caused

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

nditions contrib-
o death but not
to the terminal
condition given

PLACE OF DEATH
1
SUFFOLK
(County)
WINTHROP
(City or Town)
WINTHROP COMMUNITY HOSPITAL
No. 2
2 FULL NAME Salvatore CHARLES MARINO
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence. No. 91A Webster Street St. East Boston Mass
(Usual place of abode)
Length of stay: In place of death 12 years 40 months 40 days. In place of residence 40 years 40 months 40 days.

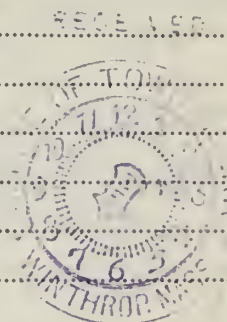
STANDARD
CERTIFICATE OF DEATH
Registered No. 151
(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)
PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

MEDICAL CERTIFICATE OF DEATH
3 DATE OF DEATH July 13 1965
(Month) (Day) (Year)
4 I HEREBY CERTIFY That I attended deceased from JULY 1 1965 to JULY 13 1965
I last saw him alive on JULY 12 1965, death is said to have occurred on the date stated above, at 11:54 m.
DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) UREMIA
(b) CEREBRAL Thrombosis
(c) GEN. ARTERIOSCLEROSIS
OTHER SIGNIFICANT CONDITIONS 2
Was autopsy performed? NO
What test confirmed diagnosis? LAB.
5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify _____
(Signature) D. Thomas Staffier, M. D.
(Address) 21 BREE ST. BOSTON Date JULY 13 1965
6 St. Michael's Cemetery Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 16 1965
7 NAME OF FUNERAL DIRECTOR Vincent Rapino
ADDRESS 9 Chelsea St. East Boston, Mass.
Received and filed JUL 14 1965
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS
8 SEX male 9 COLOR white 10 SINGLE (write the word) WIDOWED
MARRIED WIDOWED
DIVORCED UNKNOWN
11 If married, widowed, or divorced Rose Battaglia
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of _____ (Husband's name in full)
12 AGE 72 Years 72 Months 72 Days If under 24 hours _____ Hours _____ Minutes
13 Usual Occupation Barber
(Kind of work done during most of working life)
14 Industry or Business Retired
15 Social Security No. 029-03-8589
16 BIRTHPLACE (City) Italy
(State or country)
17 NAME OF FATHER Leo Marino
18 BIRTHPLACE OF FATHER (City) Italy
(State or country)
19 MAIDEN NAME OF MOTHER Grace Spano
20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)
21 Informant Connie Marino (daughter)
(Address) 91A Webster 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:
Paul C. Gaffney (mck)
(Signature of Agent of Board of Health or other)
Director of Public Health
(Official Designation) (Date of Issue of Permit) 7/14/65

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 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.

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.)

100W-5-61L-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



Middlesex

(County)

Framingham

(City or Town)

Framingham

(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No.

152

No. **Cushing Hospital**

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

2 FULL NAME **Amanda Donnelly (Delong)**
(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) Permanent Residence. No. **90 Shore Drive** St. **Winthrop, Mass.**

(City or town and State)

Length of stay: In place of death **4** years **9** months **1** days. In place of residence **92** years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **July 14 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **October 16, 1960** to **July 14, 1965**
I last saw her alive on **July 14, 1965**, death is said to have occurred on the date stated above, at **8:45pm** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Confluent bilateral bronchopneumonia** dys.
(b) **Bilateral nephrosclerosis, marked** yrs.
(c) **Generalized arteriosclerosis, severe** yrs.

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? **yes**
What test confirmed diagnosis? **Autopsy findings**

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

(Signature) **Samuel Selby, M.D.**, M. D.

(Address) **Cushing Hosp** Date **7/15/65**

6 **Forest Hills, Boston, Mass.**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 17 1965**

7 NAME OF FUNERAL DIRECTOR **Maurice W. Kirby**
Winthrop, Mass.

ADDRESS

Received and filed **AUG 4 1965**

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

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

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

(or) WIFE of **Charles Donnelly**
(Husband's name in full)

12 AGE **96** Years **9** Months **21** 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 or country) **Boston, Mass.**

17 NAME OF FATHER **George Delong**

18 BIRTHPLACE OF FATHER (City) **Canada**
(State or country)

19 MAIDEN NAME OF MOTHER **Delia Lloyd**

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

21 Informant **Medical Record Office**
Cushing Hospital
(Address) **Framingham, Mass.**

A TRUE COPY
ATTEST: **[Signature]**
(Registrar of City or Town where death occurred)

DATE FILED **July 16, 1965**

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

RECEIVED



AUG - 4 1965 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Wint. Iron, Mass.
 (City or Town making this return)

FORM R-301

PLACE OF DEATH

Suffolk
 (County)

Winthrop
 (City or Town)

STANDARD
 CERTIFICATE OF DEATH

Registered No. 153

ed for burial permit
 Board of Health
 or its Agent.

INSTRUCTIONS
 FOR
 AL CERTIFICATE

6 Sturgis
 St

IT OR TYPE
 OR CAUSES
 F DEATH

not enter
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 use for each
), (b) and (c)

does not mean
 mode of dying,
 is heart failure,
 a, etc. It means
 cause, or compli-
 which caused

ditions, if any,
 h gave rise to
 e cause (a),
 ng the under-
 cause last.

ditions contrib-
 to death but not
 to the terminal
 condition given

P. D.

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harriet B. (Tasker) Barron (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) Permanent Residence. No. 7 Woodside Park St. (City or town and State)

Length of stay: In place of death 1 years 3 months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 15 1965
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

No. 1, 19.50, to July 15, 19.65
 I last saw her live on July 14, 19.65 death is said to

have occurred on the date stated above, at 11:00 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Chronic Cholelithiasis and 2 yrs.

Due To Cholangitis (b) Obstruction of biliary 2 yrs.

Due To tract, mechanical (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

(Signature) Charles Liberman M. D.
 CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 7/16/65

6 Mt. Hope Cemetery Boston, Mass.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 17, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed JUL 19 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of George B. Barron (Husband's name in full)

12 AGE 89 Years 0 Months 6 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. 082-10-9432

16 BIRTHPLACE (City) Hyde Park, (Boston) Mass.

17 NAME OF FATHER Eli B. Tasker

18 BIRTHPLACE OF FATHER (City) Genie, N. H. (State or country)

19 MAIDEN NAME OF MOTHER Eunice Prescott

20 BIRTHPLACE OF MOTHER (City) Hyde Park, (Boston) Mass.

(State or country)

21 Informant Mrs. Irena Sprowl

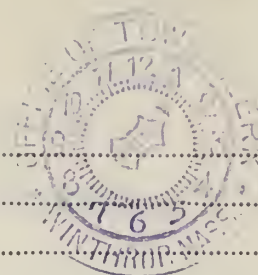
23 Pine St. Swampscott, Mass. (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (M.D.) (Signature of Agent of Board of Health or other)

Director of Public Health 7/19/65 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



JUL 19 1965 PM

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.

For burial permit
of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

FOR TYPE
OF CAUSES
OF DEATH

Not enter
than one
for each
(b) and (c)

Does not mean
of dying,
heart failure,
etc. It means
ie, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

151

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ~~Mrs.~~ Rose Bowes (Piretti)
(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) Permanent Residence. No. 797 Winthrop Ave.

Revere, Mass.

(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 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 13, 1965, to July 16, 1965.
I last saw her alive on July 15, 1965, death is said to have occurred on the date stated above, at 2:55 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion, acute 1 day
(b) Arterio Sclerotic Heart 3 mos
(c) Disease

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER
SIGNIFICANT
CONDITIONS

NO

Was autopsy performed? YES
What test confirmed diagnosis? Clinical + autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify NO

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/16/1965

6 Holy Cross Cem MAIDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 7/19/65

7 NAME OF FUNERAL DIRECTOR VINCENT RAPINO

ADDRESS 9 Chelsea ST EAST Boston

Received and filed JUL 19 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN M

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Timothy E (Husband's name in full)

12 AGE 34 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. WORK

16 BIRTHPLACE (City) BOSTON
(State or country)

17 NAME OF FATHER LOUIS PIRETTI

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country)

19 MAIDEN NAME OF MOTHER MARY Di LORENZO

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country)

21 Informant Timothy E Bowes
(Address) 797 WINTHROP AVE Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (mak)
(Signature of Agent of Board of Health or other)
Director of Public Health
(Official Designation) 7/19/65
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



JUL 19 1965 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.

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.)

100M-5-6U-938000

CORRECTED COPY

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Foxborough
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 155

PLACE OF DEATH

Norfolk
(County)
Foxborough
(City or Town)



No. 80 Main

{(If death occurred in a hospital or institution, give its NAME instead of street and number)}

2 FULL NAME Samuel J. Baker
(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) Permanent Residence. No. 913 Shirley St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 42 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 18 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1963, to July 18 1965

I last saw him alive on July 18 1965, death is said to have occurred on the date stated above, at 12:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH 2 days

Due To (b)

Due To (c)

Arteriosclerosis

3 yrs.

OTHER SIGNIFICANT CONDITIONS

Chronic myocarditis

10 yrs.

Was autopsy performed? No

What test confirmed diagnosis? Usual

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Edward R. DeRoma, M. D.
40 Front Street

(Address) Walpole, Mass. Date July 18 1965

6 Puritan Lawn Peabody, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 21 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St. Winthrop, Mass.

Received and filed AUG 4 1965

(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 WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Catherine M. Gillooly
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 73 Years 11 Month 20 Days If under 24 hours Hours Minutes

13 Usual Occupation Retired Printer
(Kind of work done during most of working life)

14 Industry or Business Printing

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER Augustus H. Baker

18 BIRTHPLACE OF FATHER (City) York
(State or country) Maine

19 MAIDEN NAME OF MOTHER Mary McLaughlin

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Kathleen E. Latter

(Address) 12 Sachem Rd., Peabody, Mass.

A TRUE COPY

ATTEST: Hugh E. West
(Registrar of City or Town where death occurred)

Agent Board of Health 7-20-65
DATE FILED

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Foxborough
(City or Town making this return)

Norfolk
(County)
Foxborough
(City or Town)

COPY OF CERTIFICATE OF DEATH

Registered No.

No. **80 Main - Foxborough, Mass.** (If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

2 FULL NAME **Samuel J. Baker**
(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) Permanent Residence. No. **913 Shirley** St. **Winthrop, Mass.**
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence **42** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **July 18 1965**
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from **Jan. 10 1963** to **July 18 1965**
I last saw him alive on **July 18 1965**, death is said to have occurred on the date stated above, at **12:30P.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Acute coronary thrombosis

(a) Due To **Arteriosclerosis**
(b) **3 yrs.**
(c) **10 yrs.**

OTHER SIGNIFICANT CONDITIONS **Chronic myocarditis**
No

Was autopsy performed? **Usual**
What test confirmed diagnosis? **No**

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify

(Signature) **Edward R. DeRoma**, M. D.
40 Front Street
Walpole, Mass. Date **July 18 65**
(Address)

6 **Puritan Lawn** **Peabody, Mass.**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 21 1965**

7 NAME OF FUNERAL DIRECTOR **Ernest P. Caggiano**
147 Winthrop St., Winthrop, Mass.

ADDRESS

Received and filed **JUL 22 1965**

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word) **Widowed**
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed or divorced **Catherine M. Gillooly**
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **74** Years **11** Months **20** Days If under 24 hours
Hours.....Minutes

13 Usual Occupation **Retired Printer**
(Kind of work done during most of working life)

14 Industry or Business **Printing**

15 Social Security No.

16 BIRTHPLACE (City) **Boston, Mass.**
(State or country)

17 NAME OF FATHER **Augustus H. Baker**

18 BIRTHPLACE OF FATHER (City) **York Maine**
(State or country)

19 MAIDEN NAME OF MOTHER **Mary McLaughlin**

20 BIRTHPLACE OF MOTHER (City) **Ireland**
(State or country)

Kathleen E. Latter

21 Informant **12 Sachem Rd., Peabody, Mass.**
(Address)

A TRUE COPY

ATTEST: **Hugh E. West**
Agent Board of Health (If death occurred in a hospital or institution, give its NAME instead of street and number) **7-20-65**

DATE FILED 19.....

FORM R-302

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.)

100W-5-6L-938000

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

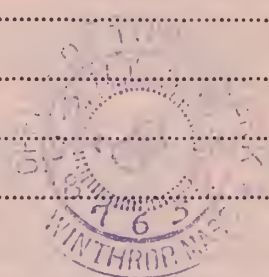
DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



JUL 22 1965 AM

FORM R-301

d for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
DEATH CERTIFICATE

OR TYPE
OR CAUSE
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

tions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

E.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 156

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 ARTHUR M. FLOYD

(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

453 Shirley

Winthrop

(a) Residence. No. St. (City or town and State)

Length of stay: In place of death. 1 years 3 months 10 days. In place of residence. years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 18 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 8, 1964, to July 18, 1965

I last saw him live on July 16, 1965 death is said to have occurred on the date stated above, at 8:57 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral thrombosis

Due To arterio sclerosis
(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

(Signature) H. B. Greenfield, M. D.

H. B. Greenfield
(Print or Type Name)

(Address) 447 Shirley St., Winthrop, Mass. Date 7-18-1965

Winthrop Cemetery, Winthrop

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 22, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed JUL 20 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN married

11 If married, widowed, or divorced HUSBAND of Mabel McKinley (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 77 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Superintendent Park Dept. (RET) (Kind of work done during most of working life)

14 Industry or Business Town of Winthrop

15 Social Security No.

16 BIRTHPLACE (City) Winthrop (State or country) Mass.

17 NAME OF FATHER William A. Floyd

18 BIRTHPLACE OF FATHER (City) Winthrop (State or country) Mass.

19 MAIDEN NAME OF MOTHER Hattie TUCKER

20 BIRTHPLACE OF MOTHER (City) ? EAST Boston (State or country) Mass

21 Informant Arthur M. Floyd Jr. 42 Main St., Winthrop (Address)

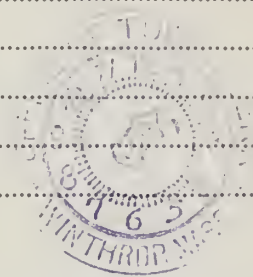
I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Jeffery (Signature of Agent of Board of Health or other)

Director of Public Health 7/30/65 (Official Designation) (Date of Issue of Permit)

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.

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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.

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.

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
case, or compli-
which caused

ditions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk
(County)Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 157

No. Cliff House Nursing Home

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary E. Kane
(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. 206 Bartlett Road
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, years 6 months days. In place of residence, years 6 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 21, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan 1965 to July 21, 1965
I last saw him alive on July 20, 1965 death is said to
have occurred on the date stated above, at 4:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular

(b) Occlusion

(c) Arteriosclerosis

INTERVAL
BETWEEN
ONSET AND
DEATH

6 mos.

3 yrs.

30 yrs.

OTHER SIGNIFICANT CONDITIONS
Organic Brain
Damage - due to tumor

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

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/22/1965

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 24, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JUL 23 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED Divorced
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Joseph M. Kane

(Husband's name in full)

12 AGE 68 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Boston, Mass
(State or country)

17 NAME OF FATHER Philip Tierney

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Margaret V. McCarthy

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant Jeanne Kane
(Address)
206 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:

Paul C. Saffrey (MCK)
(Signature of Agent of Board of Health or other)

Director of Public Health 7/23/65
(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 23 1965 AM

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burial permit
of Health
Agent.

CTIONS
OR
CERTIFICATE

R TYPE
CAUSES
DEATH

enter
than one
or each
b) and (c)

s not mean
of dying,
card failure,
c. It means
or compli-
cated caused

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he under-
use last.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



Suffolk

(County)

Winthrop

(City or Town)

Winthrop

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 158

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 Barry, Charles M., 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) No

(a) Permanent Residence. No. 15 South Ave., Winthrop St. Massachusetts
(City or town and State)

Length of stay: In place of death.....years.....months.....1.....days. In place of residence. 22 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 24 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan 1965 to July 24 1965

I last saw him live on July 23 1965, death is said to
have occurred on the date stated above, at 1:44 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Colon 1 yr.

(b) Congenital Polypsis of Colon 5 yrs.

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis Clinical, Surgical, Pathological

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP, MASS Date 7/24/1965

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 27, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed JUL 26 1965 19.....

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male	9 COLOR White	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single
---------------	------------------	---

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 22 Years.....Months.....Days | If under 24 hours
Hours.....Minutes

13 Usual Occupation Transitman
(Kind of work done during most of working life)

14 Industry or Business Engineering

15 Social Security No. 030-32-7369

16 BIRTHPLACE (City) Winthrop, Mass.
(State or country)

17 NAME OF FATHER Barry, Charles M

18 BIRTHPLACE OF FATHER (City) Winthrop
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Phelan, Dorothy

20 BIRTHPLACE OF MOTHER (City) Wakefield,
(State or country) Mass.

21 Informant Charles M. Barry

(Address) 15 South Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Giffney Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health July 26 1965
(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:

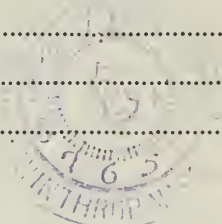
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



id for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
BIL CERTIFICATE

IT OR TYPE
OR CAUSES
DEATH

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PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

159

No. Cliff Nursing Home(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Rosa Ann Frye (Pendleton)
(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) Permanent Residence. No. 180 Pauline
(Usual place of abode)

St.

(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 July 25 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
FEB 1 1956 to JULY 25 1965
I last saw him on JULY 24 1965 death is said to
have occurred on the date stated above, at 5:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCT(b) ARTERIO-SCLEROTIC(c) HEART DIS + GENERAL(d) ARTERIO-SCLEROSIS +OTHER SIGNIFICANT CONDITIONS NEPHROSCLEROSISWas autopsy performed? NOWhat test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased?
If so, specify NO

(Signature) Myron N. King M. D.
MYRON N. KING (MD)

(Address) W. PLEASANT ST Date JULY 26 1965
WINTHROP

6 Winthrop Cemetery, Winthrop, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 27 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St, Winthrop,

Received and filed JUL 27 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Lucian Frye
(Husband's name in full)

12 AGE 85 Years 10 Months 21 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. 033-34-9172

16 BIRTHPLACE (City) Belfast
(State or country) Maine

17 NAME OF FATHER Nathan E. Pendleton

18 BIRTHPLACE OF FATHER (City) Belfast
(State or country) Maine

19 MAIDEN NAME OF MOTHER Martha A. Stover

20 BIRTHPLACE OF MOTHER (City) Belfast
(State or country) Maine

21 Informant Mrs. Gladys White

(Address) 173 Pauline 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)

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.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 160

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 Genevieve McAleenan (Honan)
(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) Permanent Residence. No. 252 Shore Drive St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 2 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 26, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan. 20, 1964, to July 26, 1965I last saw alive on July 25, 1965 death is said to
have occurred on the date stated above, at 12:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis, Generalized 2 mos

Due To Adenocarcinoma, rt. breast 1 1/2 yrs

(b)
(c)OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No(Signature) M. Traunstein, Jr., M.D.
(Print or Type Name)

(Address) 73 Bartlett Road Date July 26, 1965

6 Holyhood Cemetery Brookline
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 29, 1965

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed JUL 27 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

F White Divorced

11 If married, widowed, or divorced

HUSBAND of James McAleenan
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 61 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: Housewife

15 Social Security No. 027-14-2258

16 BIRTHPLACE (City)
(State or country) Fall River, Mass.

17 NAME OF FATHER John J. Honan

18 BIRTHPLACE OF FATHER (City) Warham, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Christina Murphy

20 BIRTHPLACE OF MOTHER (City) Providence, R.I.
(State or country)21 Informant William L. Honan
(Address) 260 Flanagan St.,
252 Shore Drive, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation) JUL 27 1965
(Date of Issue of Permit)

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 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.

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 JUL 27 1965 AM

FORM R-301

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PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. Winthrop Community Hospital

2 FULL NAME. Walter E. Morton, Jr.
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 205 Falcon St. East Boston, Mass.

Length of stay: In place of death.....years.....months9.....days. In place of residence42.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 26 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Mar 16, 1965 to July 26, 1965
I last saw him alive on July 26, 1965 death is said to
have occurred on the date stated above, at 4 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMATOSIS

Due To (b) MALIGNANT MELANOMA 5 MO.
(c) 3-12-65

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITIS 5 MO
EXCISION

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

(Signature) A. N. Caplan M. D.
A. N. CAPLAN M.D.
(Print or Type Name)

(Address) 186 BIRKBECK ST. Date 7-26-1965
EAST BOSTON

6 Woodlawn Cemetery, Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 29th 1965

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed JUL 27 1965

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 161

(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

(City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed or divorced
HUSBAND of Marie B. Murphy
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 42 Years - 13 Months - Days If under 24 hours
Hours Minutes

13 Usual Occupation Engine Man Hostler
(Kind of work done during most of working life)

14 Industry or Business B. & M. R.R.

15 Social Security No. 015-18-6466
16 BIRTHPLACE (City) East Boston Mass.
(State or country)

17 NAME OF FATHER Walter E. Morton Sr.

18 BIRTHPLACE OF FATHER (City) East Boston Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Evelyn G. Mosher

20 BIRTHPLACE OF MOTHER (City) East Boston Mass.
(State or country)

21 Informant Mrs. Marie B. Morton-wife

(Address) 205 Falcon 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:

Paul C. Gaffney Jr.
(Signature of Agent of Board of Health or other)
Director of Public Health July 26, 1965
(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.....



JUL 27 1965 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.

burial permit
of Health
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

Winthrop, Mass.

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 162

No. WINTHROP COM. HOSP

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annis, Theodore
(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 II(a) Permanent Residence. No. 11 Almont Street St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death years months 10 days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 27 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Oct 14 1957 to July 27 1965I last saw him alive on July 27 1965, death is said to
have occurred on the date stated above, at 1:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure - trans.

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To (b) Bronchial asthma

Due To (c) Emphysema

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NO
What test confirmed diagnosis? Cg. X Rays5 Was disease or injury in any way related to occupation of deceased?
If so, specify NO

(Signature) H. B. Greenfield, M. D.

(Address) 447 Spr. Way (Print or Type Name) Winthrop, Mass. Date July 27 1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 30 1965

7 NAME OF FUNERAL DIRECTOR MAURILE W. KIRBY

ADDRESS WINTHROP

Received and filed JUL 30 1965 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED11 If married, widowed, or divorced
HUSBAND of JOSEPHINE C. HORNER (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 54 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation S.U.P.T.
(Kind of work done during most of working life)

14 Industry or Business: CEMETERY

15 Social Security No. 029-05-9835

16 BIRTHPLACE (City) SOUTH BOSTON
(State or country) MASS

17 NAME OF FATHER ROBERT W. ANNIS

18 BIRTHPLACE OF FATHER (City) NOVA SCOTIA
(State or country)

19 MAIDEN NAME OF MOTHER ALICE E. SMITH.

20 BIRTHPLACE OF MOTHER (City) NOVA SCOTIA
(State or country)

21 Informant JOSEPHINE C. ANNIS

(Address) 9 ALMONT ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Goffney (M.D.)
(Signature of Agent of Board of Health or other)Director of Public Health 7/30/65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

SPACE FOR ADDITIONAL INFORMATION

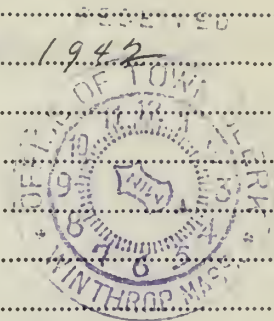
DATE OF ENTERING MILITARY SERVICE NOV 18 1942

DATE OF DISCHARGE SEPT 18 1943

RANK, RATING Pvt

ORGANIZATION AND OUTFIT ARMY

SERVICE NUMBER 31234145



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.

For burial permit
and of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)
WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

STANDARD

CERTIFICATE OF DEATH

Registered No.

163

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

EDITH (TERRIAN) BAUMEISTER

2 FULL 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) Permanent Residence. No. 80 Triton Ave

St. Winthrop, Mass

(City or town and State)

Length of stay: In place of death.....years.....months 24 days. In place of residence 26 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 28 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
7-7-65, 1965, to 7-28-65, 1965.
I last saw him live on 7-28-65, 1965, death is said to
have occurred on the date stated above, at 2:52 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia terminal 48hr
(b) Carcinomatosis - 1hr
(c) Carcinoma of ovary 1 yr

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? ho
What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph A. Gregoire, M. D.
Joseph A. Gregoire
(Print or Type Name)
(Address) 194 Washington Ave 7-28-65

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 31, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
147 Winthrop St., Winthrop

ADDRESS

Received and filed JUL 30 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED married
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles F. Baumeister
(Husband's name in full)

12 AGE 80 Years 1 Months 1 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. 024-09-0608

16 BIRTHPLACE (City) Chayze
(State or country) New York

17 NAME OF FATHER Jules A. Therrien

18 BIRTHPLACE OF FATHER (City) Quebec
(State or country)

19 MAIDEN NAME OF MOTHER Amelia Willett

20 BIRTHPLACE OF MOTHER (City) Vermont
(State or country)

21 Informant Charles F. Baumeister
80 Triton Ave., Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (mak)
(Signature of Agent of Board of Health or other)
Director of Public Health 7/30/65
(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.....



JUL 30 1965 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

FORM R-301

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Wint' on
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 164

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



No. Cliff Nursing Home

{(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 Frederick Barkan-White
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 26 Locust Street St.
(Usual place of abode) (City or town and State)

Length of stay: In place of death years 3 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 28, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1964 to July 28, 1965
I last saw him alive on July 27, 1965 death is said to have occurred on the date stated above, at 5:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular Occlusion 2 mos

Due To (b) Cerebral Arteriosclerosis 5 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS Parkinson's Syndrome 5 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

(Signature) Charles L. Berman M. D.

(Print or Type Name) CHARLES L. BERMAN

(Address) WINTHROP, MASS. Date 7/28/1965

6 Cambridge Cemetery, Cambridge,
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 30, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. March

ADDRESS 174 Winthrop St. Winthrop

Received and filed JUL 30 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced HUSBAND of Laura Louise Keife
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 84 Years 2 Months 22 Days If under 24 hours Hours Minutes

13 Usual Occupation retired Pharmacist
(Kind of work done during most of working life)

14 Industry or Business commercial drug store

15 Social Security No. 025-02-5781

16 BIRTHPLACE (City) Nova Scotia
(State or country)

17 NAME OF FATHER James Parker WHITE

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER FRANCES M. K.

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Mrs. Orrin F. White

(Address) 352 Commonwealth Ave. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney (mark)
(Signature of Agent of Board of Health or other)

Director of Public Health 7/30/65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



JUL 30 1965 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.

OUT-OF-TOWN
Middlesex
(County)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Malden
(City or Town making this return)

1 PLACE OF DEATH
Malden
(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 165

No. Buchanan Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Vileta Marchand
(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. 14 Seymour St. Winthrop Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 7 months days In place of residence years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 29 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Dec 64 to July 29 65
I last saw her alive on 7-29-65, death is said to have occurred on the date stated above, at 6:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma
Carcinoma

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Cerebral

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) [Signature] M. D.
(Print or Type Name)

(Address) 624 Main St. Date 7/30 1965

Camb. Catholic Cambridge
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 31 1965

7 NAME OF FUNERAL DIRECTOR Charles D. Keefe

ADDRESS 2175 Mass. Ave. Camb.

Received and filed August 2 1965
[Signature] Registrar

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name at wife in full) Joseph A. Marchand (Husband's name in full)

12 AGE 45 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: at home (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. Lowell Mass

16 BIRTHPLACE (City) (State or country)

17 NAME OF FATHER William Norton

18 BIRTHPLACE OF FATHER (City) (State or country) Cannot be learned

19 MAIDEN NAME OF MOTHER Louise Diette

20 BIRTHPLACE OF MOTHER (City) (State or country) Cannot be learned

21 Informant Mrs. Doris Duffe (Address)

14 Seymour St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

65 John F. [Signature] (Signature of Agent of Board of Health or other)

Div. Public Health July 30 1965 (Official Designation) 46699 (Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED



AUG - 4 1965 PM

FORM R-301

Suffolk

(County)

Winthrop

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 166

Bay View Nursing Home

No.

(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Eric N Swenson (Svenson)

(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) Permanent Residence. No.

174 Pauline Street

St.

(Usual place of abode)

(City or town and State)

Length of stay: In place of death. 5 years. 60 months. days. In place of residence. 60 years. months. days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH July 30 1965
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
 Oct 10 1955, to July 30 1965

 I last saw him live on July 29 1965, death is said to
 have occurred on the date stated above, at 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) coronary insufficiency

(b) arteriosclerosis - heart 10 yrs

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS
 Carcinoma of prostate
 Peri pheral vasculardisease

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

(Signature) H. B. Greenfield, M. D.

(Print or True Name)

(Address) 447 Summer St, Boston, Mass. Date July 30 1965

 6 Winthrop Winthrop
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 2 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed AUG 2 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

 8 SEX Male 9 COLOR White 10 SINGLE (write the word)
 MARRIED
 WIDOWED Widowed
 DIVORCED
 UNKNOWN

 11 If married, widowed, or divorced
 HUSBAND of Augusta Johnson
 (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

 12 AGE 86 6 18
 Years. Months. Days If under 24 hours
 Hours. Minutes

 13 Usual Occupation Engineer
 (Kind of work done during most of working life)

14 Industry or Business Pumping Station

15 Social Security No. None

 16 BIRTHPLACE (City) Sweden
 (State or country)

17 NAME OF FATHER Bengt Swenson

 18 BIRTHPLACE OF FATHER (City) Sweden
 (State or country)

19 MAIDEN NAME OF MOTHER Bengta

 20 BIRTHPLACE OF MOTHER (City) Sweden
 (State or country)

 21 Informant Vivian Uliano
 (Address) 174 Pauline Street Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Galleney (Signature of Agent of Board of Health or other)

 Director of Public Health 8/2/65
 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



AUG 2 1965 11

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-303

or burial permit
of Health
Agent.

SUFFOLK

(County)

WINTHROP

(City or Town)

18 Hale Avenue

No.

Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 167

2 FULL NAME DONALD MacELREE (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) W.W.2

(a) Permanent Residence. No. 18 Hale Avenue St. Wintthrop, Mass.
(City or town and State)

Length of stay: In place of death 16 years months days. In place of residence 16 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 31, 1965
(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.)

GUNSHOT WOUND OF HEAD WITH
AVULSION OF BRAIN

5 Accident, suicide, or homicide (specify) SUICIDE
Date and hour of injury July 31, 1965

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? Home.
(Specify type of place)

Manner of injury SELF-INFLICTED GUNSHOT WOUND
(How did injury occur?)

Nature of injury AVULSION OF BRAIN

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.

(Address) 25 Shattuck St.
Boston, Mass. Date 7/31/65

7 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL August 3, 1965

8 NAME OF FUNERAL DIRECTOR Alfred B. March
ADDRESS 174 Wintthrop St. Winthrop, Mass.
AUG 4 1965

Received and filed 19.

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

male white

12 If married, widowed, or divorced
HUSBAND of Pearl Minerva Benson
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 45 Years 25 Days If under 24 hours
Hours Minutes

14 Usual Occupation: retired Police Officer
(Kind of work done during most of working life)

15 Industry or Business: Somerville Police Dept.

16 Social Security No. 016-15-2151

17 BIRTHPLACE (City) Cambridge
(State or country) Massachusetts

18 NAME OF FATHER Arthur Merrill MacElree

19 BIRTHPLACE OF FATHER (City) Pennsylvania
(State or country)

20 MAIDEN NAME OF MOTHER Blanche Evelyn Hodgdon

21 BIRTHPLACE OF MOTHER Gloucester
(State or country) Massachusetts

22 Informant Mrs. Donald N. MacElree
(Address)

18 Hale Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the death or burial or cremation took place:

Paul C. Gaffney
(Signature of Agent or Board of Health or other)
District Public Health Officer, 3, 1965
(Official Designation) (Date of Issue of Permit)

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.

100M-5-61-938000

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 3-31-44

DATE OF DISCHARGE 8-27-46

RANK, RATING Corporal

ORGANIZATION AND OUTFIT Marine Corps

SERVICE NUMBER 953585

.....

.....

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.

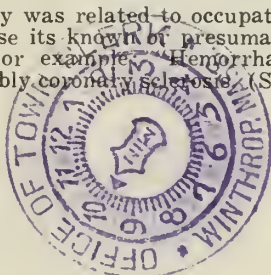
(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following 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)."

RECEIVED



AUG 4 1944

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

168

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

BRIGHTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 04590

No. ST. ELIZABETH'S HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME MRS. CLARA E. (STOREY) WARD
(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. 152 PLEASANT
(Usual place of abode)St. WINTHROP, MASS.
(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 29 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
APRIL 17, 1965 to APRIL 29, 1965
I last saw her live on APRIL 29, 1965 death is said to
have occurred on the date stated above, at 10:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL THROMBOSIS 4 DAYS

(b) ART-SCL HEART DISEASE MANY YRS

(c) PNEUMONIA 5 DAYS

OTHER SIGNIFICANT CONDITIONS POST-OP CHOLECYSTECTOMY 12 DAYS

Was autopsy performed? NO
What test confirmed diagnosis? LP, EKG, X-RAY5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Ralph M. Porter, M.D.

(Print or Type Name) RALPH M. PORTER, M.D.

(Address) ST. ELIZ. HOSP. Date 4-29 1965

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 1 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed MAY 4 1965

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
Widow UNKNOWN11 If married, widowed, or divorced
HUSBAND of Herbert F Storey (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)12 AGE 85 Years 6 Months 20 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. 014-22-8004

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER William S Storey

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country)

19 MAIDEN NAME OF MOTHER Annie M

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)

21 Informant William O Hanson

(Address) 300 Park View Ave. Daly City Cal.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:C. O. 8661 Kenneth W. Hurd
(Signature of Agent of Board of Health or other)(Official Designation) April 30 1965
(Date of Issue of Permit)burial permit
with board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEPRINT OR TYPE
USE OR CAUSES
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,
thrombosis, etc. It means
the disease, or complica-
tions 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
cause condition given
(a).

JUG 19 1965

A TRUE COPY ATTEST:

William J. Kane.
City Registrar


AUG 18 1965 AM


AUG 19 1965 AM

FORM R-301

1-11

to be filed for burial permit
with Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
CAUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean
the mode of dying,
such as heart failure,
asthenia, etc. It means
the disease, or complica-
tions 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
in (a).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



Suffolk

(County)

Boston

(City or Town)

No. BOSTON CITY HOSPITAL

A.

2 FULL NAME John A. Williams
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 101 Cowper St. East Boston
(City or town and State)

Length of stay: In place of death years 1 months 2 days. In place of residence 46 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 2 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That ~~deceased~~ ^{was a patient}
April 1, 1965, to May 2, 1965

death is said to
have occurred on the date stated above, at 8:25 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary edema

(b) Myocardial infarction

(c)

OTHER
SIGNIFICANT CONDITIONS Cerebral vascular
accident

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

(Signature) Arthur A. Williams M.D.
Arthur A. Williams M.D.
(Print or Type Name)
(Address) BOSTON CITY HOSPITAL 5/2, 1965

Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 5th 1965

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed MAY 4 1965

William J. Kane
(Registrar)

A TRUE COPY ATTEST:

STANDARD
CERTIFICATE OF DEATH

Registered No. 14675

(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, WW 1
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word)
MARRIED WIDOWED Married
DIVORCED UNKNOWN

11 If married, widowed or divorced
HUSBAND of Agnes M. Lane
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

AGE 29 Years Months Days
If under 24 hours
Hours Minutes

13 Usual Occupation Custodian-Retired
(Kind of work done during most of working life)

14 Industry or Business Boston Public Library

15 Social Security No. 033-34-1567

BIRTHPLACE (City) St. John N.B.
(State or country)

17 NAME OF FATHER John A. Williams

18 BIRTHPLACE OF FATHER (City) California
(State or country)

19 MAIDEN NAME OF MOTHER Mary Ann Kelley

20 BIRTHPLACE OF MOTHER (City) N.B.
(State or country)

21 Informant Mrs. Agnes M. Williams-wife

(Address) 104 Cowper St., E. Boston

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:

William J. Kane.

City Registrar



AUG 13 1965 AM



AUG 13 1965 AM

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

170

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

STANDARD
CERTIFICATE OF DEATH

Registered No. 04851

(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) NO2 FULL NAME. Panteley Griseuk
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 170 Cliff Ave. St. Winthrop, Massachusetts

(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, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 29, 1965, to May 5, 1965

I last saw him alive on May 5, 1965, death is said to

have occurred on the date stated above, at 7:20 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PYELONEPHRITIS ACUTE

INTERVAL
BETWEEN
ONSET AND
DEATH

UNK.

Due To BENIGN PROSTATIC HYPERPLASIA

(b) 9 YRS.

Due To

(c)

OTHER SIGNIFICANT CONDITIONS RENAL CELL CARCINOMA 14 YRS.

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

(Signature) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ass'n. Dir., Mass. Gen'l. Hosp. Date May 5, 1965

6 WOODLAWN EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 10 1965

7 NAME OF FUNERAL DIRECTOR ANDREW SEFCHUCK
105 WASHINGTON AVE

ADDRESS CHELSEA MASS

Received and filed MAY 11 1965

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

MALE WHITE MARRIED

DIVORCED

UNKNOWN

11 If married, widowed, or divorced

HUSBAND of CATHERINE (SEWCHUK) GRISEUK

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years 10 Months 20 Days

If under 24 hours

Hours Minutes

13 Usual Occupation LABORER

(Kind of work done during most of working life)

14 Industry or Business REVERE RUBBER CO.

15 Social Security No. 032-03-8810

16 BIRTHPLACE (City) SEWEL

(State or country) RUSSIA

17 NAME OF FATHER

UNKNOWN

18 BIRTHPLACE OF FATHER (City)

(State or country) UNKNOWN

19 MAIDEN NAME OF MOTHER

UNKNOWN

20 BIRTHPLACE OF MOTHER (City)

(State or country) UNKNOWN

21 Informant JOHN GRISEUK

(Address) 9 ARLINGTON ST. CHELSEA MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued:

7P. Shara C. 08956

(Signature of Agent of Board of Health or other)

May 7, 1965

(Official Designation) (Date of Issue of Permit)

be filed for burial permit
with Board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEPRINT OR TYPE
CAUSE OR CAUSES
OF DEATHdo not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
a mode of dying,
such as heart failure,
themia, etc. It means
a disease, or complica-
tions 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
cause condition given
(a).

m.c.

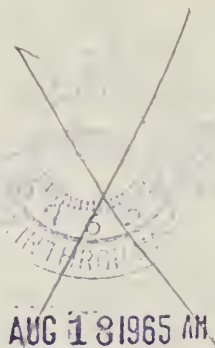
180
57
XLocal Director
base use only

BACK 1965

1-5-64-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

~~~~
AUG 18 1965 AM


AUG 19 1965 AM

RM R-301

for burial permit
of Health
Agent.

CTIONS
OR
CERTIFICATE

R TYPE
CAUSES
ATH

enter
an one
or each
) and (c)

not mean
of dying,
art failure,
It means
or compli-
ch caused

, if any,
e rise to
use (a),
e under-
use last.

was contrib-
ish but not
be terminal
tion given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



SUFFOLK
(County)

BOSTON
(City or Town)

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

05218

No. CHILDRENS HOSPITAL MEDICAL CENTER. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MICHELLE OCCHIPINTI
(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) Permanent Residence. No. 293 MAIN STREET, St. WINTHROP, MASS.
(Usual place of abode) (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 MAY 17, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
May 13, 1965, to May 17, 1965
I last saw her on May 17, 1965 death is said to
have occurred on the date stated above, at 3:20 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia

(b) Leukemia

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

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

(Signature) William E. Boyle, M. D.
WILLIAM E. BOYLE JR.
(Print or Type Name)
(Address) 300 LONGWOOD AVE Date 19

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 18, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop
MAY 19 1965
Received and filed 19

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED SINGLE
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 1 Years 3 Months 17 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
(State or country) Mass.

17 NAME OF FATHER Domenic Occhipinti

18 BIRTHPLACE OF FATHER (City) Medford
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Sieglinde Spitznagel

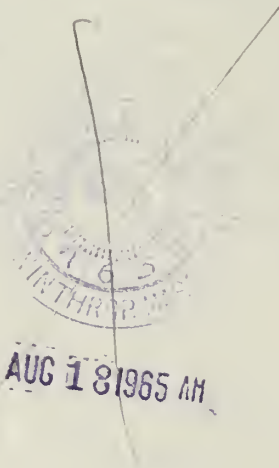
20 BIRTHPLACE OF MOTHER (City) Germany
(State or country)

21 Informant Domenic Occhipinti
293 Main St., Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
C09329 Permitted and
(Signature of Agent of Board of Health or other)
may 18, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



AUG 18 1965 AM



AUG 19 1965 AM

FORM R-301

SUFFOLK

(County)

BOSTON

(City or Town)

PLACE OF DEATH

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

172

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 05313

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 Catherine Titman
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, *nlo*
if so specify WAR)

(a) Permanent Residence. No. 66 Shore Drive St. Winthrop, Massachusetts

(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 19, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
May 11, 1965 to May 19, 1965I last saw her alive on May 19, 1965, death is said to
have occurred on the date stated above, at 10:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Subhepatic Abscess unk. Wks

(b) Due To Cholangitis unk. Wks

(c) Due To Cholelithiasis Yrs

OTHER SIGNIFICANT CONDITIONS Hypertensive Heart Disease 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

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date May 19, 1965

Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 22 1965

7 NAME OF FUNERAL DIRECTOR Frederick J. MacRath

ADDRESS East Boston

Received and filed MAY 25 1965

William J. Kane

(Official Designation)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Female White MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Albert Titman

(Husband's name in full)

12 AGE 83 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. CNOL.

16 BIRTHPLACE (City) Boston MASS.
(State or country)

17 NAME OF FATHER James Carlin

18 BIRTHPLACE OF FATHER (City) Vermont
(State or country)

19 MAIDEN NAME OF MOTHER Alice Curtis

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) MASS.21 Informant Ruth McCarthy
Address 79 Lincoln St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or cremation permit was issued:F.P. Shaca 009416
(Signature of Agent of Board of Health)May 20, 1965
(Date of Issuance of Permit)

A TRUE COPY ATTEST:

be filed for burial permit
with Board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEPRINT OR TYPE
CAUSE OR CAUSES
OF DEATHdo not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
a mode of dying,
such as heart failure,
suffocation, etc. It means
the disease, or complication,
or conditions 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
cause condition given
(a).

19 1965

Ineral Directors

Please use only

BLACK Ink.

ON-5-64-938000

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

~~AUG 18 1965 AM~~

AUG 19 1965 AM

The Commonwealth of Massachusetts

173

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. 05343

PLACE OF DEATH

Suffolk
(County)Boston
(City or Town)

No. 125 Parker Hill Avenue

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME David Silverman

(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 Seafoam Avenue
(Usual place of abode)St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 12.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 21 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
May 6, 1965, to May 21, 1965.
I last saw him alive on May 20, 1965, death is said to
have occurred on the date stated above, at 7:15 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH
monthsDEATH WAS CAUSED BY: IMMEDIATE CAUSE
Carcinoma of lung with metastases
(a) to cervical spine.Due To
(b)Due To
(c)OTHER SIGNIFICANT CONDITIONS Arteriosclerotic heart
disease yearsWas autopsy performed? ..
What test confirmed diagnosis? xray exam. and clinical
course5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Joel P. Goldthwait, M.D.

Joel C. Goldthwait, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 1100 Beacon St., Date May 21, 1965

Brookline, Mass.

6 BETH ISRAEL CEM. NO. READING

Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 23 1965

7 NAME OF FUNERAL DIRECTOR MURRAY GOLDMAN

ADDRESS 174 Ferry St. MAIDEN

Received and filed MAY 25 1965

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 ESTHER GREEN
(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 9 Months Days
If under 24 hours Hours Minutes13 Usual Occupation: INSURANCE MAN
(Kind of work done during most of working life)

14 Industry or Business: RET. LIFE, RETIRED

15 Social Security No. 025-01-5083

16 BIRTHPLACE (City) MOSCOW
(State or country) RUSSIA

17 NAME OF FATHER HARRY SILVERMAN

18 BIRTHPLACE OF FATHER (City) MOSCOW
(State or country) RUSSIA

19 MAIDEN NAME OF MOTHER JENNIE (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) MOSCOW
(State or country) RUSSIA21 Informant (Address) EDWARD SILVERMAN
151 6th St. PROVIDENCE, R.I.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
FOR
CERTIFICATEgiving
OF DEATHit enter
than one
for each
b) and (c)is not mean
of dying,
card failure,
ic. It means
or compli-
which causedis, if any,
we rise to
ause (a),
he under-
use last.ions contrib-
ash but not
the terminal
dillon given

13

Chapter 137,
1954, requires
ne to print or
e cause or
of death on
ificates, and
48, Acta of
quires Phys-
print or type
ier signature.

9 1965

28145

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

~~AUG 18 1965 AM~~

AUG 18 1965 AM

FORM R-301

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

(City or Town making this return)

174

STANDARD

CERTIFICATE OF DEATH

Registered No. 05683

New England Center Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Nellie Christoforo

(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) Permanent Residence. No. 27 Bowdoin St.

St. Winthrop, Mass.

(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 31 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from May 15 1965, to May 31 1965

I last saw her alive on May 31 1965 death is said to have occurred on the date stated above, at 9:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CHRONIC PYELONEPHRITIS
(b) DUE TO CHRONIC PYELONEPHRITIS 5 years

DUE TO (c) BLEEDING DUODENAL ULCER 10 years

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? YES
What test confirmed diagnosis? BLEEDING UREA LEVEL5 Was disease or injury in any way related to occupation of deceased NO
If so, specify

(Signature) J. A. RIVERA M.D. M. D.

(Print or Type Name)

(Address) Date.....19.....

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 3, 1965

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS Revere

Received and filed JUN 4 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widow

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Dominic Christoforo (Husband's name in full)

12 AGE 74 5/30/91 Years Months 1 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. Boston

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER John B. Biggi

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Teresa Finochetti

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant Mrs. Norma Conway

(Address) 27 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)

A TRUE COPY ATTEST:

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

M.S.

9 1965

100M-5-64-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



SEP 12 1965 AM

OUT - OF - TOWN

The Commonwealth of Massachusetts

175

FORM R-301

SUFFOLK

(County)

BOSTON

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

 Boston
 (City or Town making this return)

 STANDARD
 CERTIFICATE OF DEATH

Registered No. 07905

PLACE OF DEATH

MASSACHUSETTS GENERAL HOSPITAL

 (If death occurred in a hospital or institution,
 St. { give its NAME instead of street and number)

Gertrude

PHYSICIAN — IMPORTANT

2 FULL NAME

IDA G. Whittle

(If deceased is a married, widowed or divorced woman, give also maiden name.)

110 Grovers Avenue

 (Was deceased a
 U. S. War Veteran,
 if so specify WAR) NO.

(a) Permanent Residence. No.

214 Endicott Ave

St.

Revere

(City or town and State)

Length of stay: In place of death, 3 years, months, 3 days. In place of residence, 60 years, months, days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH June 5 1965
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY That deceased died from
 621.1.1.1. 19.65 to 19.65, 19.65
 I last saw him alive on 19.65, death is said to
 have occurred on the date stated above, at 6:22 P.M.

 INTERVAL
 BETWEEN
 ONSET AND
 DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Subdural Hematoma Unk. days

(b) Due To Echymosis, scalp Unk. days

(c) Due To

OTHER SIGNIFICANT CONDITIONS Breast Carcinoma, recurrent 18 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

(Signature) C. L. Clay, M.D.

 Charles L. Clay, M.D.
 (Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date 19

 6 Wyoming Cemetery Melrose, Mass.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 8 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Wintrop St. Wintrop.

Received and filed JUN 11 1965

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED Widowed Divorced UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 93 Years 6 Months 6 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

Social Security No. none

16 BIRTHPLACE (City) Boston (State or country) Massachusetts

17 NAME OF FATHER Charles Phillip Whittle

18 BIRTHPLACE OF FATHER (City) Charlestown, Mass. (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Helen Mabel Blaisdell

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Massachusetts

21 Informant Paul Swift

(Address) 192 Bartlett Rd. 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) June 8, 1965
 (Official Designation) (Date of Issue of Permit)

 To be filed for burial permit
 with Board of Health
 or its Agent.

 INSTRUCTIONS
 FOR
 MEDICAL CERTIFICATE

 PRINT OR TYPE
 CAUSE OR CAUSES
 OF DEATH

 do not enter
 more than one
 cause for each
 of (a), (b) and (c)

 This does not mean
 the mode of dying,
 such as heart failure,
 asthma, 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
 in (a).

 Countersigned
 (Med. Examiner
 Dr. Luongo)
 ee over
 M. S.

Funeral Director

Please use only

BLACK Ink.

100M-5-64-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar.

RECEIVED



SEP 19 1965 AM

FORM R-301

X OUT-OF-TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS176
(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No. 07919

CHILDREN'S HOSPITAL MEDICAL CENTER (If death occurred in a hospital or institution,
No. St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARK A WRIGHT

(If deceased is a married, widowed or divorced woman, give also maiden name.)

22 HARVARD

WINTHROP, MASSACHUSETTS

(a) Permanent Residence. No.
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death years months 9 days. In place of residence 14 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 7 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from May 29 1965 to June 7 1965

I last saw him live on June 7 1965 death is said to have occurred on the date stated above, at 9:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congenital ht disease

INTERVAL
BETWEEN
ONSET AND
DEATH

14da

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Cardiac cath

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) Jane Pitt M.D.

(Address) 300 Longwood Ave June 8, 1965

WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

(a) DATE OF BURIAL JUNE 8 1965

(b) NAME OF FUNERAL DIRECTOR MARCELLA KIRBY

ADDRESS WINTHROP

Received and filed JUN 9 1965

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN SINGLE

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years Months 14 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 (State or country) MASS

17 NAME OF FATHER RONALD R WRIGHT

18 BIRTHPLACE OF FATHER (City) EAST BOSTON (State or country)

19 MAIDEN NAME OF MOTHER CONSTANCE PERRIN

20 BIRTHPLACE OF MOTHER (City) MEDFORD (State or country) MASS

21 Informant RONALD R WRIGHT

(Address) 22 HARVARD ST 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)

C/008 C 68 65

(Official Designation) (Date of Issue of Permit)

Filed for burial permit
with Board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEINT OR TYPE
OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)This does not mean
mode of dying,
as heart failure,
pneumonia, etc. It means
disease, or compli-
cations which caused
death.Conditions contrib-
uting to death but not
causing the under-
lying cause last.Conditions contrib-
uting to death but not
causing the under-
lying condition given

9 1965

9-63-936348

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



SEP 19 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. **177**

No. **Danvers State Hospital, Hathorne** (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME **Frank Taylor**

(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) Permanent Residence. No. **10 Surfside Avenue**

St. **Winthrop**

(City or town and State)

Length of stay: In place of death.....years.....months **29** days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **July 15 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **June 16 65** to **July 15 65**

I last saw him on **July 15 1965** death is said to have occurred on the date stated above, at **8:20p** in.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Hypostatic pneumonia

(a)

xxxx

(b) **arteriosclerotic heart disease Yrs**

(c) **generalized arteriosclerosis Yrs**

OTHER SIGNIFICANT CONDITIONS

NO

Was autopsy performed?

What test confirmed diagnosis? **Clinical & Laboratory**

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) **Willard M. Hausman**, M. D.

Willard M. Hausman

(Address) **Hathorne, Mass** Date **7-15- 65**

Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 19 65**

7 NAME OF FUNERAL DIRECTOR **Frank H. Carr Funeral**

ADDRESS **Charlestown, Mass**

7-21-65

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) **widowed**
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced **Unknown**

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 **94 3 26** AGE.....Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation: **Unknown** (Kind of work done during most of working life)

Industry or Business: **Unknown**

15 Social Security No. **Boston Mass**

16 BIRTHPLACE (City) (State or country)

17 NAME OF FATHER **Frank Taylor**

18 BIRTHPLACE OF FATHER (City) (State or country) **England**

19 MAIDEN NAME OF MOTHER **Frances Woodbury**

20 BIRTHPLACE OF MOTHER (City) (State or country) **Philadelphia Pennsylvania**

Helen A. Ziolkowski

21 Informant: **Danvers, Mass**

A TRUE COPY

Tracy I. Flagg

Ronell J. Toomey

ATTEST: **Dir of Public Health July 16, 1965**

DATE FILED.....19.....

RM R-302

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.)

100M-5-6L-938000

965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



AUG 11 01985 AM

or burial permit
rd of Health
s Agent.

CTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

es not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

ms, if any,
ave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
dition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 178

Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

Louis M. Aronson

2 FULL 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) Permanent Residence. No. 100 Almont St. Winthrop

(City or town and State)

Length of stay: In place of death years months 4 days. In place of residence 18 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 1 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 1965 to Aug 1 1965

I last saw him live on Aug 1 1965. death is said to have occurred on the date stated above, at 1:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 4 days

Due To (b) Arteriosclerotic Heart 2 months

(c) Disease.

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

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS. 8/1/65
(Print or Type Name)

6 American Friendship West Rox.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 2 1965

7 NAME OF FUNERAL DIRECTOR Morris W. Brezniak
470 Harvard St. Brookline

ADDRESS

Received and filed AUG 2 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced Goldie Doodlesack
HUSBAND OF (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 64 years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Accountant
(Kind of work done during most of working life)

14 Industry or Business Office Manager

15 Social Security No. 022-03-5969

16 BIRTHPLACE (City) Boston
(State or country)

17 NAME OF FATHER Hyman Aronson

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Fannie Unknown Price

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

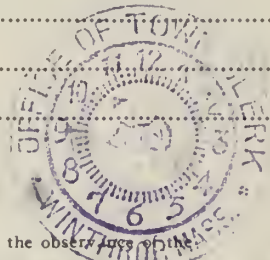
21 Informant Goldie Aronson
100 Almont St. Winthrop

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)
Director of Public Health Aug 2, 1965
(Official Designation) (Date of Issue of Permit)

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.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Nahant

(City or Town making this return)

Essex

(County)

Nahant

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No.

179

No. Jesmond Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Delia J. (Connolly) Grimes

(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.

250 Winthrop 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 6 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

August 1

1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Oct. 21

1965

to August 1

1965

I last saw him alive on July 5, 1965, death is said to

have occurred on the date stated above, at 10:30a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Infarction of Myocardium

Due To

Atherosclerosis

(b)

Yrs.

Due To

(c)

OTHER

SIGNIFICANT
CONDITIONS

Rheumatoid Arthritis

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

Harold S. Rubin

Harold S. Rubin

(Signed) M. D.

519 Humphrey St. Swampscott

(Address) Date 8/2/65

6 Holyhood Cem/ Brookline

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

19

7 NAME OF
FUNERAL DIRECTOR

Arthur L. O'Maley

ADDRESS

Winthrop, Mass.

Received and filed

9-8-65

19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

F

9 COLOR

W

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

Michael Grimes

(or) WIFE of

(Husband's name in full)

12

AGE

35

Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation

Housewife

(Kind of work done during most working life)

14 Industry

or Business

Own Home

15 Social Security No.

Galway

16 BIRTHPLACE (City)

Ireland

(State or country)

17 NAME OF

FATHER

Patrick Connolly

18 BIRTHPLACE OF

FATHER (City)

Ireland

(State or country)

19 MAIDEN NAME

OF MOTHER

Bridget McGrath

20 BIRTHPLACE OF

MOTHER (City)

Ireland

(State or country)

21 Informant

(Address)

Merlin Grimes

35 Edgehill Rd. Winthrop Mass.

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

August 2

19 65

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.)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



FORM R-301

For burial permit
 of Health
 Agent.

INSTRUCTIONS
 FOR
 CERTIFICATE

OR TYPE
 OR CAUSES
 DEATH

not enter
 than one
 for each
 (b) and (c)

Does not mean
 of dying,
 heart failure,
 etc. It means
 which caused

ons, if any,
 gave rise to
 cause (a),
 the under-
 cause last.

itions contrib-
 death but not
 the terminal
 condition given

PLACE OF DEATH

SUFFOLK (County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 FULL NAME MYRLE SMITH (CHESLEY)
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 11 LIGHT ST. COURT

West LYNN

Registered No.

180

(City or town and State)

Length of stay: In place of death.....years.....months.....7 days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST 4, 1965
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
 APRIL 1965 to AUGUST 4, 1965

I last saw her alive on AUGUST 4, 1965, death is said to
 have occurred on the date stated above, at 6:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERALIZED CARCINOMATOSIS

INTERVAL
BETWEEN
ONSET AND
DEATH

2 MOS

(b) INFIETRATING DUCT CARCINOMA

4 MOS

(c) RIGHT BREAST

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

(Signature) M. Traunstein Jr. M. D.

M. TRAUNSTEIN JR. M.D.

(Address) 73 BARTLETT RD. WINTHROP, MASS. Date AUG 4, 1965

6 BLOSSOM HILL CONCORD N.H.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG 7, 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY

ADDRESS WINTHROP, MASS.

Received and filed AUG 6 1965

A TRUE COPY ATTEST:

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

(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
 DIVORCED UNKNOWN WIDOWED

11 If married, widowed, or divorced
 HUSBAND of (Give maiden name of wife in full)
 (or) WIFE of WILLIAM M. SMITH
 (Husband's name in full)

12 AGE 54 Years 3 Months 14 Days If under 24 hours
 Hours Minutes

13 Usual Occupation HAIR DRESSER
 (Kind of work done during most of working life)

14 Industry or Business: BEAUTY PARLOR

15 Social Security No. 043-07-0582

16 BIRTHPLACE (City) CONCORD
 (State or country) N.H.

17 NAME OF FATHER WARREN
 WILLIAM S. CHESLEY

18 BIRTHPLACE OF FATHER (City) CONCORD
 (State or country) N.H.

19 MAIDEN NAME OF MOTHER DELLA HEATH

20 BIRTHPLACE OF MOTHER (City) CONCORD
 (State or country) N.H.

21 Informant MRS. ROBERT LYONS

(Address) ACTON, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (R)

(Signature of Agent of Board of Health or other)

Director of Public Health August 6, 1965
 (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

AUG 16 1965 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.

for burial permit
ard of Health
ts Agent.

CTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

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cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. **190 PAULINE**



STANDARD CERTIFICATE OF DEATH

Registered No. **181**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **BENIAMINO CORLETO**
(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) Permanent Residence, No. **190 PAULINE** St. **WINTHROP MASS.**
(Usual place of abode) (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 **August 6, 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
April 6, 1965 to **August 6, 1965**
I last saw him alive on **August 6, 1965** death is said to
have occurred on the date stated above, at **6:15 p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Hodgkin's Disease**

INTERVAL
BETWEEN
ONSET AND
DEATH
2 yrs.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Bronchopneumonia 1 wk.

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

(Signature) **Joseph G. Famiglietti**, M. D.

Joseph A. Famiglietti

(Print or Type Name)

(Address) **1180 Beacon St.** Date **8/6 1965**

6 **HOLY CROSS** **BROOKLINE, MASS.** **MALDEN**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **AUGUST 11, 1965**

7 NAME OF FUNERAL DIRECTOR **DIPIETRO & VAZZA**
11 HENRY ST, EAST BOSTON
ADDRESS

Received and filed **AUG 9 1965** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED **WIDOWED** **WIDOWED**
DIVORCED **UNKNOWN**

11 If married, widowed, or divorced,
HUSBAND of **MARIANNA LA GRETA**
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE **95** Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation **PROPRIETOR TAILOR (RET.)**
(Kind of work done during most of working life)

14 Industry or Business **MEN'S CLOTHING FACTORY**

15 Social Security No. **030-05-293**

16 BIRTHPLACE (City).....
(State or country) **ITALY**

17 NAME OF FATHER **JOSEPH CORLETO**

18 BIRTHPLACE OF FATHER (City).....
(State or country) **ITALY**

19 MAIDEN NAME OF MOTHER **CAROLINE PASCARELLI**

20 BIRTHPLACE OF MOTHER (City).....
(State or country) **ITALY**

21 Informant **MARION SABIA**
190 PAULINE ST, WINTHROP
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney
(Signature of Agent of Board of Health or other)

Director of Public Health Aug 9, 1965
(Official Designation) (Date of Issue of Permit)

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.



AUG - 9 1965 PH

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.)

100M-5-61-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Reverse
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 182

Suffolk

(County)

Revere

(City or Town)

No. Grover Manor Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME. Clare M. Scoberia (Burns)
(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) Permanent Residence. No. 114 Lincoln St. Winthrop
(City or town and State)

Length of stay: In place of death. 3 years. months. days. In place of residence. 13 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 8, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Aug. 1, 1965, to Aug. 8, 1965.
I last saw her alive on Aug. 8, 1965, death is said to
have occurred on the date stated above, at 8:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Congestive heart failure

(a) 4mons. INTERVAL BETWEEN ONSET AND DEATH

Due To
(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?
If so, specify No

(Signature) S. A. DeLuca, M. D.

(Address) 550 Park Ave. 8/8 65
Revere Date 19

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 11, 1965

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

Winthrop

Received and filed SEP 3 1965

(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
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced
HUSBAND of Francis M.
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 53 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Secretary
(Kind of work done during most of working life)

14 Industry or Business: U. S. General Services

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER Edward P. Burns

18 BIRTHPLACE OF FATHER (City) Providence
(State or country) R. I.

19 MAIDEN NAME OF MOTHER Margaret A. Taylor

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Francis M. Scoberia
(Address) 114 Lincoln St., Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED August 12, 1965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



SEP - 3 1965 AM

For burial permit
of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

Do not enter
more than one
cause for each
(b) and (c)

Death does not mean
of dying,
heart failure,
etc. It means
the death which caused

Death, if any,
due to (a),
the under-
cause last.

Deaths contrib-
ute but not
the terminal
condition given

1.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **183**

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 Mrs. Edith M. Richards (Cole)
(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) Permanent Residence. No. 24 Quincy Ave. St. Winthrop
(City or town and State)

Length of stay: In place of death 2 years 7 months 7 days. In place of residence 42 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 12, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from June 21, 1965 to Aug 12, 1965
I last saw her alive on Aug 11, 1965, death is said to have occurred on the date stated above, at 2:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebro Vascular Occlusion
(b) 8 weeks

Due To Cerebral Arteriosclerosis 2 yrs.
(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

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 8/12/1965

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 14, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop Street, Winthrop

Received and filed AUG 16 1965

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE Married
(Write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Alfred Owen Richards
(Give maiden name of wife in full) (or) WIFE of Alfred Owen Richards
(Husband's name in full)

12 AGE 89 Years 11 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 own home

15 Social Security No. none

16 BIRTHPLACE (City) New Brunswick
(State or country)

17 NAME OF FATHER David William Cole

18 BIRTHPLACE OF FATHER (City) Holton
(State or country) Maine

19 MAIDEN NAME OF MOTHER Ann Ferris

20 BIRTHPLACE OF MOTHER (City) New Brunswick
(State or country)

21 Informant Alfred O. Richards
(Address) 24 Quincy Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Giffney (s)
(Signature of Agent of Board of Health or other)
Director of Public Health 8/13/65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

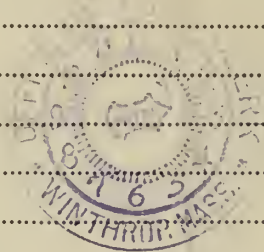
DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



RULES OF PRACTICE

AUG 16 1965 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.

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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.

or burial permit
rd of Health
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RUCTIONS
FOR
CERTIFICATE

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118

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

STANDARD CERTIFICATE OF DEATH

Registered No. 184

(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Corcoran, William
(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) Permanent Residence. No. 19 Enfield Rd. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 4 years 4 months 4 days. In place of residence 50 years 50 months 50 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 13 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Sept. 1964 to August 13, 1965
I last saw him alive on Aug 11, 1965 death is said to
have occurred on the date stated above, at 7:45 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease
(b) arteriosclerosis-gen.
(c) you

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS Cardiac Decompensation
Coronary artery disease weeks

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Joseph J. Corcoran, M. D.

(Address) 194 Washington St. 8-13-65
Winthrop

6 Holy Cross Cemetery Malden Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 16 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed AUG 16 1965 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced
HUSBAND of Agnes C. Molloy
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

12 AGE 81 Years 81 Months 81 Days
If under 24 hours
Hours 81 Minutes

13 Usual Occupation Retired Buyer
(Kind of work done during most of working life)

14 Industry or Business Fish

15 Social Security No. _____

16 BIRTHPLACE (City) East Boston
(State or country) Mass

17 NAME OF FATHER Patrick Corcoran

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Good

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Agnes C. Corcoran
(Address) 19 Enfield Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health Aug 14 1965
(Official Designation) (Date of Issue of Permit)

V.R.V.

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

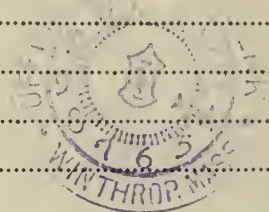
DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



AUG 16 1965 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.

burial permit
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PLACE OF DEATH

1

Suffolk

(County)

Winthrop

(City or Town)

No.

Winthrop Community Hospital

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

Mr. William Wollenhaupt

(a) Permanent Residence. No.

159 Harris St.

St.

Revere,

Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....7.....days. In place of residence.....55.....years.....months.....7.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

August 13, (Day) 1965 (Year)

4 I HEREBY CERTIFY, That I attended deceased from

August 4, 1965, to August 13, 1965

I last saw him on August 12, 1965, death is said to
have occurred on the date stated above, at 2:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Accident

INTERVAL
BETWEEN
ONSET AND
DEATH

7 dys

Due To

(b) Malignant Hypertension

5 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?

If so, specify

no

(Signature)

John F. Pepi M.D.

, M. D.

(Address)

East Boston Mass. Date 8/13/ 1965

6 Woodlawn

Place of Burial or Cremation

Everett

(City or Town)

DATE OF BURIAL

Aug. 16

19

65

7 NAME OF
FUNERAL

DIRECTOR Howard S Reynolds

Winthrop, Mass

ADDRESS

Received and filed

AUG 16 1965

19

A TRUE COPY ATTEST:

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 185

{(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)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced

HUSBAND of Angela Aucella
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)

12

AGE 64 Years 5 Months 11 Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation Foreman

(Kind of work done during most of working life)

14 Industry

or Business: Maintenance

15 Social Security No.

022-07-4082

16 BIRTHPLACE (City)

New York City

(State or country) New York

17 NAME OF

FATHER William Wollenhaupt

18 BIRTHPLACE OF

FATHER (City) New York City

(State or country) New York

19 MAIDEN NAME

OF MOTHER Helena Lohmann

20 BIRTHPLACE OF

MOTHER (City) New York City

(State or country) New York

21 Informant

Angela Wollenhaupt

159 Harris St. Revere, Mass

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Giffney (B)
(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

AUG 16 1965 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.

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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.

burial permit
of Health
Agent.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop, Mass.
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **186**

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 **Belsky, Max**

(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) Permanent Residence. No. **433 Winthrop St.,** St. **Winthrop, Mass.**

(City or town and State)

Length of stay: In place of death.....years.....months **1**.....days. In place of residence **43** years **8** months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **AUG 17 1965**
(Month) (Day) (Year)

HEREBY CERTIFY, That I attended deceased from

DEC 30 60, 19**60**, to **AUG 17 1965**

I last saw him alive on **AUG 17 1965**, death is said to
have occurred on the date stated above, at **9:51 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **CEREBRAL VASCULAR ACCT** 5 DAYS

Due To **ARTERIO SCLEROTIC HEART DYS**

(c) **GENERAL ARTERIO SCLEROSIS** 4 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

(Signature) **Myron N. King** M. D.

MYRON N. KING
(Print or Type Name)

(Address) **222 PLEASANT ST. Date AUG 17 1965**

6 **Workman's Circle Cemetery, Melrose**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **August 18, 1965** 19

7 NAME OF FUNERAL DIRECTOR **B. SCHLOSSBERG & SONS**

ADDRESS **1257 BLUE HILL AVE, MATAPAN**
AUG 18 1965

Received and filed 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN **Married**

11 If married, widowed, or divorced **Lena Perlman**

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **78** Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation **Tailor**
(Kind of work done during most of working life)

14 Industry or Business: **Tailor shop**

15 Social Security No.

16 BIRTHPLACE (City) **Russia**
(State or country)

17 NAME OF FATHER **Mordecai Kalman Belsky**

18 BIRTHPLACE OF FATHER (City) **Russia**
(State or country)

19 MAIDEN NAME OF MOTHER **Chia CARMEN**
e.n.b.l.

20 BIRTHPLACE OF MOTHER (City) **Russia**
(State or country)

21 Informant **Sydney Beldon**
44 Nardell Rd., Newton Centre

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney (mod)

(Signature of Agent of Board of Health or other)
Director of Public Health 8/18/65
(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

AUG 18 1965 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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1 R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 187

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. MAYFLOWER NURSING HOME

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. ELIZABETH BERNARD (Perry)
(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) Permanent Residence. No. 788 BROADWAY St. CHELSEA, MASS.
(City or town and State)

Length of stay: In place of death. years 2 months. days. In place of residence 22 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST 17, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
March 10, 19. to Aug 10, 19. 65.
I last saw her alive on Aug 10, 1965, death is said to
have occurred on the date stated above, at 1:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

(b) Due To Cerebral Arteriosclerosis 3 yrs
(c) 15

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus

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

(Signature) Charles F. Ferrera M.D.
CHARLES F. FERRERA M.D.

154 BENNINGTON ST. (Prior Type Name)
EAST BOSTON, MASS. Date 8-17-1965

6 HOLY CROSS CEMETERY MALDEN, MASS.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUGUST 20, 1965

7 NAME OF FUNERAL DIRECTOR JOHN G. WELSH

ADDRESS 718 BROADWAY CHELSEA, MASS.

Received and filed AUG 19 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN WIDOW

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of JOHN BERNARD (Husband's name in full)

12 AGE 80 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: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City). PRINCE EDWARD ISLAND
(State or country) CANADA

17 NAME OF FATHER PETER PERRY

18 BIRTHPLACE OF FATHER (City). CANADA
(State or country)

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City). CANADA
(State or country)

21 Informant ROSE GAUTREAU (DAUGHTER)

(Address) 139 FENNO ST. REVERE, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (a)

(Signature of Agent of Board of Health or other)
Director of Public Health August 19, 1965
(Official Designation) (Date of Issue of Permit)

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

AUG 19 1965 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 septic-mia), 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.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 188

No. 94 Terrace Ave.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Francis W. Burke

(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

94 Terrace Ave.

Winthrop

(a) Permanent Residence. No.
(Usual place of abode)

St. Winthrop
(City or town and State)

Length of stay: In place of death 2 years.....months.....days. In place of residence 2 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 17, 1965

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from

May 14, 1965, to Aug 17, 1965

I last saw him alive on Aug 16, 1965, death is said to
have occurred on the date stated above, at 6:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

Due To (b) arteriosclerosis

Due To (c) gen

INTERVAL
BETWEEN
ONSET AND
DEATH

yo
yo

OTHER
SIGNIFICANT
CONDITIONS Senility

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Joseph P. Caggiano M. D.

(Print or Type Name) Ernest P. Caggiano

(Address) Winthrop Date Aug 18, 1965

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 19, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed AUG 19 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED married

11 If married, widowed, or divorced HUSBAND of Charlotte Flynn

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 83 Years 8 Months 15 Days If under 24 hours Hours Minutes

13 Usual Occupation Paper Ruler (ret)
(Kind of work done during most of working life)

14 Industry or Business Eastern Manufacturing

15 Social Security No. 004-01-1012

16 BIRTHPLACE (City) Springfield
(State or country) Mass.

17 NAME OF FATHER Jeremiah Burke

18 BIRTHPLACE OF FATHER (City) Springfield
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Bedley

20 BIRTHPLACE OF MOTHER (City) Springfield
(State or country) Mass.

21 Informant Charlotte Burke
94 Terrace Ave., Winthrop

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Caggiano
(Signature of Agent of Board of Health or other)
Director of Public Health 8/18/65
(Official Designation) (Date of Issue of Permit)

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.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 189

No. 190 PAULINE

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MICHAEL SABIA
(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) Permanent Residence. No. 190 PAULINE

St. WINTHROP MASS
(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 August 20, 1965
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
December 19, 64, to Aug. 20, 1965

I last saw him live on August 20, 1965 death is said to
have occurred on the date stated above, at 11:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of head of tumor 9 mos.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Metastatic disease mos.

Was autopsy performed?

NO

What test confirmed diagnosis? operation.

5 Was disease or injury in any way related to occupation of deceased NO
If so, specify

(Signature) Joseph A. Famiglietti MD
JOSEPH A. FAMIGLIETTI
(Print or Type Name)

(Address) 1180 BEACON ST Aug 21, 1965

HOLY CROSS BROS. MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUGUST 24, 1965

7 NAME OF FUNERAL DIRECTOR DIPIETRO & VAZZA

11 HENRY ST, EAST BOSTON
ADDRESS

Received and filed AUG 23 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of MARION CORLETO
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 61 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation MANAGER
(Kind of work done during most of working life)

14 Industry or Business RESTAURANT

15 Social Security No 021-26-4416

16 BIRTHPLACE (City) BOSTON MASS
(State or country)

17 NAME OF FATHER JOSEPH SABIA

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER THEODORA PREZIOSO

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant MARION SABIA
190 PAULINE STREET, WINTHROP, MASS
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney
(Signature of Agent of Board of Health or other)
Director of Public Health Aug 23, 1965
(Official Designation) (Date of Issue of Permit)

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.

AUG 2 3 1965 AM



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **190**

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 **Teresa Agnes Sterndale (Gilmartin)**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WARI) No.

(a) Permanent Residence. No. **12 Cherry Street** St. **Winthrop**
(Usual place of abode) (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 **August 24 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 10, 1960, to Aug. 24, 1965

I last saw her on **Aug. 14, 1965** death is said to
have occurred on the date stated above, at **11 a. m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Acute myocardial infarction** **2 hrs**

Due To **Arteriosclerotic heart**
(b) **disease with coronary** **5 mos**
sclerosis Generalized

Due To
(c) **arteriosclerosis** **1 yr**

OTHER
SIGNIFICANT
CONDITIONS **none**

Was autopsy performed? **no**
What test confirmed diagnosis? **clinical & lab**

5 Was disease or injury in any way related to occupation of deceased **no**
If so, specify

(Signature) **M. Traunstein, Jr.** M. D.
M. Traunstein, Jr. M. D.
(Print or Type Name)

(Address) **73 Bartlett Rd. Date 8-24-1965**
Winthrop, Mass.

6 **Elmwood Cemetery, Methuen, Mass**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **August 27, 1965**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St. Winthrop.**

Received and filed **AUG 25 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED **widowed**
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **William Walton Sterndale**
(Husband's name in full)

12 AGE **67** Years **2** Months **24** Days If under 24 hours
Hours.....Minutes

13 Usual Occupation **Licensed Practical Nurse**
(Kind of work done during most of working life)

14 Industry or Business **Chelsea General Hospital**

15 Social Security No. **018-05-4301**

16 BIRTHPLACE (City) **Lawrence**
(State or country) **Massachusetts**

17 NAME OF FATHER **James Gilmartin**

18 BIRTHPLACE OF FATHER (City) **England**
(State or country)

19 MAIDEN NAME OF MOTHER **Mary Beck**

20 BIRTHPLACE OF MOTHER (City) **England**
(State or country)

21 Informant **Mrs. Franklin R. Farrow**

(Address) **12 Cherry St. Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Giffney (Signature of Agent of Board of Health or other)

Director of Public Health Aug 25, 1965 (Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

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 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.

for burial permit
ard of Health
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KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **191**

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. *98 Tafts ave*(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME *Annie M (Crowley) Guilfoil*

(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. *98 Tafts 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 *2* years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *August 27 1965*
(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 *1:10 A.M.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Death presumably due*Due To *to natural causes.*(b) *Winthrop Board of Health*
(c) *Charles Liberman, M.D.*OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? *No*

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? *No*
If so, specify(Signature) *Charles Liberman*, M. D.
CHARLES LIBERMAN
(Print or Type Name)(Address) *WINTHROP, MASS* Date *8/27/1965*6 *Oak Grove Cemetery Medford*
Place of Burial or Cremation (City or Town)DATE OF BURIAL *Aug 30 1965*7 NAME OF FUNERAL DIRECTOR *Madeline G. Casey*ADDRESS *295 Wash ave Chelsea*Received and filed *AUG 30 1965*.....19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *F* 9 COLOR *wh.* 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED *widowed*
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of *Arthur G Guilfoil*
(Husband's name in full)12 AGE *74* Years *1* Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: *soldier*
(Kind of work done during most working life)14 Industry or Business: *Wm J Murdock Co*15 Social Security No. *014-380-3821*16 BIRTHPLACE (City) *Chelsea*
(State or country) *Mass*17 NAME OF FATHER *Frank Crowley*18 BIRTHPLACE OF FATHER (City) *Ireland*
(State or country)19 MAIDEN NAME OF MOTHER *Annie O'Neil*20 BIRTHPLACE OF MOTHER (City) *Ireland*
(State or country)21 Informant (Address) *Edward F Guilfoil*
*98 Tafts ave Winthrop*I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul E. Goffman
(Signature of Agent of Board of Health or other)
Director of Public Health Aug 30, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

*Dr. Charles
L. H. H. H. H. H.
357 Division
Winthrop*

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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **192**

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 **MARY THOMAS (PATRIQUIN)**
(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) Permanent Residence. No. **63 BEACON STREET**St. **WINTHROP MASS.**

(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 27 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Aug. 2, 1964, to Aug. 27, 1965

I last saw him alive on **Aug. 27, 1965** death is said to
have occurred on the date stated above, at **2:00 PM**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **acute myocardial infarction 13 days**(b) **arteriosclerotic heart disease 3 yrs**(c) **generalized arteriosclerosis 5 yrs**OTHER SIGNIFICANT CONDITIONS **bilateral bronchial pneumonia 4 days**Was autopsy performed? **no**What test confirmed diagnosis? **clinical & lab**

5 Was disease or injury in any way related to occupation of deceased?
If so, specify **no**

(Signature) **M. Traunstein, Jr.** M. D.

(Print or Type Name)

(Address) **73 Bartlett Rd.** Date **Aug 27, 1965**

6 **Woodlawn Crematory** **Everett**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Aug 30 1965**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop Mass.**Received and filed **Aug 30 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)**Female****White****MARRIED****WIDOWED****DIVORCED****UNKNOWN**

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

William T Thomas

(Husband's name in full)

12 **89** **2** **25**
Years Months DaysIf 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)
(State or country) **Nova Scotia**17 NAME OF FATHER **James Patriquin**18 BIRTHPLACE OF FATHER (City)
(State or country) **Nova Scotia**19 MAIDEN NAME OF MOTHER **Eliza Matatall**20 BIRTHPLACE OF MOTHER (City)
(State or country) **Nova Scotia**21 Informant **Gertrude T. Rogers**(Address) **63 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:

Paul C. Gaffney (S)

(Signature of Agent of Board of Health or other)

Director of Public Health

(Date of Issue of Permit) **Aug 30, 1965**

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.

AUG 30 1965 AM



R-303

burial permit
of Health
Agent.

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.

100M-5-61-938000

1965

PLACE OF DEATH

SUFFOLK

(County)
WINTHROP

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

193

(City or Town making this return)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 08558

No. VETERANS ROAD, WINTHROP

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Lena

Dislor

(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) Permanent Residence. No. 379 Shirley

St. Winthrop, Massachusetts

(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 August 28, 1965
(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.)

FRACTURE OF CERVICAL SPINE

5 Accident, suicide, or homicide (specify) Accident,
Date and hour of injury August 28, 1965

IF ACCIDENTAL, was injury causally related to the death? YES

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 PEDESTRIAN STRUCK BY AUTO
(How did injury occur?)

Nature of injury TRAUMA TO HEAD AND NECK

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.

25 Shattuck St., Boston 8/28 65

(Address) Date

Tifereth Israel of Winthrop, Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 30, 1965

8 NAME OF FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed SEP 1 1965

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Kalan H. Dislor
(Husband's name in full)13 AGE 70 Years Months Days If under 24 hours
Hours Minutes14 Usual Occupation: House-wife
(Kind of work done during most of working life)

15 Industry or Business: At home

16 Social Security No.

17 BIRTHPLACE (City) Russia
(State or country)

18 NAME OF FATHER Edward Romm

19 BIRTHPLACE OF FATHER (City) Russia
(State or country)

20 MAIDEN NAME OF MOTHER Sarag Silver

21 BIRTHPLACE OF MOTHER (City) Russia
(State or country)22 Informant Saul Dislor
(Address)

270 River Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:F.P. Glaca C14843
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) Aug 30, 1965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

RECEIVED
OFFICE OF THE
SHERIFF
7 6 5
WINTHROP, MASS.

RULES OF PRACTICE

SEP - 9 1965 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 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.)"

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11 West 42nd Street Dept Health September 8, 1965

Dear Sirs, I wish

to let you know that

I have been informed

and please

kindly acknowledge of death one

of our friends that died in

this office in 1964

Do not hesitate in

the future to call on me if any

directed problems should arise,

as I am a pleasure taking with

you

Sincerely

R. J. Rogers
Sen. Staff Assoc. opor.

R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. **194**

PLACE OF DEATH

SUFFOLK

(County)

Winthrop

(City or Town)

NURSING

MAYFLOWER REST HOME

No.

(If death occurred in a hospital or institution
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SARAH CANDELIERE

(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) Permanent Residence. No.

82 MARION

St. EAST Boston

(City or town and State)

Length of stay: In place of death. 2 years. months. days. In place of residence. 41 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 31 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Sun 19/1965 to Aug 31 1965
I last saw her alive on Aug 7 1965 death is said to
have occurred on the date stated above, at 4:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

Due To (b) Arteriosclerosis

Due To (c) —

OTHER SIGNIFICANT CONDITIONS U

INTERVAL
BETWEEN
ONSET AND
DEATH15 min
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(Signature) Charles J. Ferreri, M.D.
(Print or Type Name)(Address) 151 Beacon St. Date 9/1/65
St. Michael's Boston6 St. Michael's Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 3 1965

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS EAST Boston

Received and filed SEP 1 1965 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Dominic CANDELIERE
(Husband's name in full)12 AGE 83 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. CNAL

16 BIRTHPLACE (City) BUENOS AIRES
(State or country) ARGENTINA

17 NAME OF FATHER Michael Montemureo

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER SCRAFINA C.B.L.

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Arthur Candeliere
(Address) 82 MARION ST. E. BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney, M.D.

(Signature of Agent of Board of Health or other)

Director of Public Health 9/1/65
(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

8000

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:

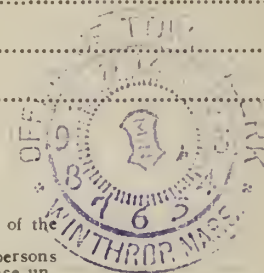
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



X

PLACE OF DEATH

Middlesex

(County)

Somerville

(City or Town)

No. Somerville Hospital, Crocker

The Commonwealth of Massachusetts



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Somerville

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 415

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank Sammartino

(If deceased is a married, widowed or divorced woman, give also maiden name.)

119 Revere

Winthrop

(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 August 7, 1965

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3/30/65, to 8/7/65

I last saw him live on 8/7/65, death is said to have occurred on the date stated above, at 7:20p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

INTERVAL BETWEEN ONSET AND DEATH

2 days

Due To (b) Arteriosclerosis

unknown

Due To (c)

OTHER SIGNIFICANT CONDITIONS Severe secondary anemia

3-4 wks

Was autopsy performed? No

What test confirmed diagnosis? Clinical evidence

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John A. Fraser, M.D.

(Address) 172 Summer St. Somerville, Mass. 8/7/65

6 Winthrop Cem., Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 11, 1965

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

Winthrop, Mass.

ADDRESS SEP 17 1965

Received and filed

(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 DIVORCED UNKNOWN Married

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Theresa Amerino (Husband's name in full)

12 AGE 69 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Musician

(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. 022-05-7087

16 BIRTHPLACE (City) Boston, Mass. (State or country)

17 NAME OF FATHER Pasquale Sammartino

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Ruffina DeLeonard

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

Mrs. Theresa Sammartino

21 Informant (Address) 119 Revere St. Winthrop, Mass.

A TRUE COPY

ATTEST: William J. Conway (Registrar of City or Town where death occurred)

DATE FILED Aug. 10, 1965

SPACE FOR ADDITIONAL INFORMATION.....

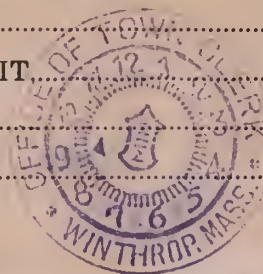
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



SEP 17 1965 AM

The Commonwealth of Massachusetts

Essex

(County)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

Danvers

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 196

Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Robert H. Welsh

2 FULL 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) Permanent Residence. No. 48 Sargent St. Winthrop, Mass
(City or town and State)

Length of stay: In place of death.....years 2 months 18 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 26 1965
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from June 8 65 to August 26 65
I last saw him alive on August 26 65 at 6:40 a.m. death is said to have occurred on the date stated above, at 6:40 a.m.DEATH WAS CAUSED BY: IMMEDIATE CAUSE
arteriosclerotic hrt dis YrsINTERVAL
BETWEEN
ONSET AND
DEATH

(a) Due Generalized arteriosclerosis

(b) Due To
(c)

OTHER SIGNIFICANT CONDITIONS Chronic emphysema Yrs

Was autopsy performed? NO
What test confirmed diagnosis? Clinical & Lab5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) Willard M. Hausman M. D.
Willard M. Hausman

(Address) Hathorne, Mass 8-26 65

6 Winthrop Cemetery Winthrop, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 28 1965

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
Winthrop, Mass

ADDRESS

Received and filed SEP 28 1965 8-30 65

(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 DIVORCED UNKNOWN singl

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 82 8 11 Days If under 24 hours
Years Months Days Hours Minutes13 Usual Occupation: Retired Buyer
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 012-03-2855
16 BIRTHPLACE (City) East Boston
(State or country) Mass

17 NAME OF FATHER Michael J. Welsh

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Julia M. Calla

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass21 Informant Georgie T. Brimigion
(Address) Danvers, Mass.

A TRUE COPY

Tracy I. Flagg Daniel J. Toomey

ATTEST: Dir of Public Health 8-26-65

DATE FILED 1965

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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

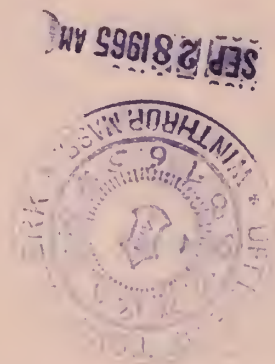
DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 FULL NAME

CATHERINE O'BRIEN (McCOOL)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

445 Meridian St.,

(a) Permanent Residence. No.

St.

(City or town and State)

Length of stay: In place of death years months 7 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept 1 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 19 1962 to Sept 1 1965

I last saw her alive on Sept 1 1965, death is said to have occurred on the date stated above, at 8:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia - terminal 4 da

(b) Carcinomatosis now

(c) Carcinoma of breast 2 yr

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

(Signature) Joseph J. Magrath M. D.

(Print or Type Name) Joseph J. Magrath

(Address) 194 Washington St. Date 9-1 1965

6 Star of the Sea Marblehead
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 4 1965

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS East Boston

Received and filed SEP 3 1965

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

197

(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
E. Boston Mass.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)
(or) WIFE of John J. O'Brien
(Husband's name in full)12 AGE 62 years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Houseworker
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No. 0381

16 BIRTHPLACE (City, State or country) Marblehead MASS

17 NAME OF FATHER Peter McCool

18 BIRTHPLACE OF FATHER (City, State or country) Not Known

19 MAIDEN NAME OF MOTHER Sarah Meservey

20 BIRTHPLACE OF MOTHER (City, State or country) Not Known

21 Informant James O'Brien

(Address) 445 Meridian 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:Paul C. Gaffney (M.D.)
(Signature of Agent of Board of Health or other)Director of Public Health 9/3/65
(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.

M R-301

Burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No. 198

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. Sarah Rogolsky (Reingold)
(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) Permanent Residence. No. 29 Neptune Ave. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....1 days. In place of residence.....32 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 3, 1965

(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 1:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
to natural causesDue To probably acute myocardial
occlusion on basis of history andOTHER Electrocardiograms,
SIGNIFICANT Winthrop of Board
CONDITIONS Charles Liberman had

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 9/3/1965

6 JEWISH BENEVOLENT - W. Box.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 9 - 3 1965

7 NAME OF FUNERAL DIRECTOR ARNOLD COLOV

ADDRESS 1668 BEACON ST., BROOKLINE

Received and filed SEP 3 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Benjamin Rogolsky
(Husband's name in full)12 72 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 At Home

15 Social Security No. None

16 BIRTHPLACE (City). Russia
(State or country)

17 NAME OF FATHER Issur Reingold

18 BIRTHPLACE OF FATHER (City). Russia
(State or country)

19 MAIDEN NAME OF MOTHER Shifra (unknown)

20 BIRTHPLACE OF MOTHER (City). Russia
(State or country)

21 Informant Mr. Saul Rogolsky

(Address) 3 Brigham Street, Watertown

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Gaffney (mark)
(Signature of Agent of Board of Health or other)Director of Public Health 9/3/65
(Official Designation) (Date of Issue of Permit)

19763

Medical examiner notified - referred to Board of Health.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

SEP - 3 1965 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.

FORM R-301

for burial permit
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PLACE OF DEATH

1

Suffolk

(County)

Winthrop

(City or Town)

No. Cliff House Nursing Home

2 FULL NAME Ressie Brenda Rand (Banks)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 50 Wilshire

(Usual place of abode)

St. Winthrop

(City or town and State)

Length of stay: In place of death. 19 years. months. 19 days. In place of residence. 52 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 4 1965
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
Feb. 2er, 1962, to Sept. 4, 1965.I last saw h. alive on Sept. 4, 1965 death is said to
have occurred on the date stated above, at 6:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Cerebral hemorrhage-massive

(a) 18 hrs

(b) Arteriosclerotic & hyper-

(c) tensive heart disease

Due To Generalized arterioscler-

(c) osis. 3 yrs

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No.

What test confirmed diagnosis? Clin. & Lab.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) M. Traunstein, Jr. M.D.

(Address) 73 Bartlett Rd. Winthrop

(Date) Sept. 4 1965

6 Roodridge Cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 8, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed SEP 6 1965

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

199

(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) NC.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female white 9 COLOR 10 SINGLE (write the word)
MARRIED widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Hovey Rand (Husband's name in full)

12 AGE 25 Years 6 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.

16 BIRTHPLACE (City) Windsor

(State or country) Nova Scotia

17 NAME OF FATHER Benjamin Nickerson Banks

18 BIRTHPLACE OF FATHER (City) Windsor

(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Elizabeth Gabriel

20 BIRTHPLACE OF MOTHER (City) Windsor

(State or country) Nova Scotia

21 Informant Hovey Rand, Jr.

(Address) 7 Calumet Lane, Marplehead

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney

(Signature of Agent of Board of Health or other)

Director of Public Health Sept 7 1965

(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 - 7 1965 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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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

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The Commonwealth of Massachusetts

RM R-301

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PLACE OF DEATH

Suffolk
(County)Wintrop
(City or Town)KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 200

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. Betty Jacobsen (Hronek)

(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) Permanent Residence. No. 21 Cross St.

St. Winthrop

(City or town and State)

Length of stay: In place of death years months 11 days. In place of residence 5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 5 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
June 10 1965 to 9/5/65

I last saw or alive on 9/5/65, 19., death is said to

have occurred on the date stated above, at 4:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized Carcinomatosis

Due To Carcinoma of ovary

(b) Carcinoma of ovary

(c) Carcinoma of ovary

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clin. & Lab.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) M. Traunstein Jr. M. D.

M. Traunstein Jr. M.D.
(Print or Type Name)

(Address) 73 Bartlett Winthrop 9/5/65

6 Woodlawn Crematory Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 7 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed 19.

SEP 7 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR Wh 10 SINGLE (write the word)
MARRIED
WIDOWED Married
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Iver Jacobsen
(Husband's name in full)12 AGE 51 Years 6 Months 20 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. 055-09-4876

16 BIRTHPLACE (City) Cleveland Ohio
(State or country)

17 NAME OF FATHER Hronek, John

18 BIRTHPLACE OF FATHER (City) Czechoslovakia
(State or country)

19 MAIDEN NAME OF MOTHER Crandall, Dorothy

20 BIRTHPLACE OF MOTHER (City) Ohio
(State or country)

21 Informant Iver Phillip Jacobsen

(Address) 21 Cross St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Coffney (s)
(Signature of Agent of Board of Health or other)Director of Public Health
(Official Designation)SEP 7 1965
(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 7 1965 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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for burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Wintthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 201

Suffolk
(County)
Wintthrop
(City or Town)



No. DayView Nursing Home

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edna Louise MacDonald (Hiltz)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NC.

(a) Permanent Residence. No. 41 Willow Avenue
(Usual place of abode)

St. Wintthrop
(City or town and State)

Length of stay: In place of death. 1 years 9 months 0 days. In place of residence. 50 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 8, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct. 3, 1960, to Sept. 8, 1965
I last saw her alive on Sept. 7, 1965, death is said to
have occurred on the date stated above, at 5:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Arteriosclerotic heart
disease

Due To Generalized arterio-
(b) scleriosis

Due To
(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

3 yrs

5 yrs

OTHER
SIGNIFICANT
CONDITIONS
Severe crippling
hypertrophic arthritis
& Chronic cystitis

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

(Signature) M. Traubstein, Jr., M.D.
M. TRAUBSTEIN, JR., M.D.
(Print or Type Name)

(Address) 73 Bartlett Rd. Date Sept. 9, 1965
Wintthrop, Mass. 02152

6 Wintthrop Cemetery, Wintthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 10, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. G. H. H. H.

ADDRESS 174 Wintthrop St. Wintthrop, Mass.

Received and filed SEP 10 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED
DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Clarence William MacDonald
(Husband's name in full)

12 AGE 77 Years 6 Months 10 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. 010-09-0-30

16 BIRTHPLACE (City) Nova Scotia
(State or country)

17 NAME OF FATHER Richard Hiltz

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Alma Spidel

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

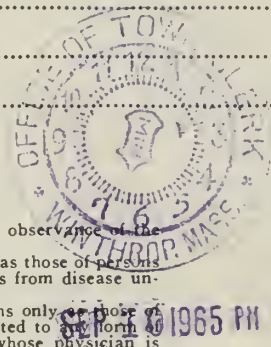
21 Informant Jean Elizabeth MacDonald
(Address) 41 Willow Avenue

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)
Director of Public Health Sept 10 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 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:

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1-303

Burial permit
of Health
gent.

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.

100M-5-61-938000

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

(City or Town making this return)

Registered No. 202

No. Winthrop Community Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY J. FARRELL
(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) Permanent Residence. No. 291 River Road, Winthrop St. (City or town and State)

Length of stay: In place of death.....years.....months.....7.....days. In place of residence 44.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 13, 1965
(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.)

FRACTURE OF FEMUR.
PULMONARY EMBOLISM.

5 Accident, suicide, or homicide (specify) Accident.

Date and hour of injury September 5, 1965.

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 Fall to floor.

(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?

If so, specify

(Signed) Michael A. Luongo, M. D.

Boston (Print or Type Name) 9/13 65

7 Holyhood Cemetery Brookline
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL September 16 1965

8 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop 1965

Received and filed 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 76 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation: At Home (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. Boston

17 BIRTHPLACE (City) State of country) Mass

18 NAME OF FATHER James Farrell

19 BIRTHPLACE OF FATHER (City) State or country) Baltimore Maryland

20 MAIDEN NAME OF MOTHER Bridget Leary

21 BIRTHPLACE OF MOTHER (City) State or country) Co. Kerry Ireland

22 Informant Grace Morse (Address) 291 River Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney

(Signature of Agent of Board of Health or other)

Director of Public Health Sept 14, 1965 (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 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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Woburn
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. **203**

1 PLACE OF DEATH

Middlesex
(County)

Woburn
(City or Town)

Choate Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

DOROTHY M. ROBERTS (O'Leary)

(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) Permanent Residence. No. (Usual place of abode)

59 Crest Ave.

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, 17 years, 45 months, 17 days. In place of residence, 45 years, 45 months, 17 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 13, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 84 to Sept. 13, 65
I last saw him alive on Sept. 13, 65, death is said to have occurred on the date stated above, at 3:50 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cirrhosis of liver with liver failure 1 yr.

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS renal failure 1 wk. gastro intestinal bleeding 2 days

Was autopsy performed? yes
What test confirmed diagnosis? autopsy & liver function tests

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Dr. Kenneth A. Nesbitt, M. D.
Choate Hospital

(Address) Woburn, Mass. 9-14-65
Date

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL SEPTEMBER 16, 65

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed OCT 5 1965

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR white 10 SINGLE (write the word) Married
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of John M. Roberts
(Husband's name in full)

12 AGE 55 Years -- Months -- Days If under 24 hours Hours Minutes

13 Usual Occupation: Home
(Kind of work done during most of working life)

14 Industry or Business: Housewife

15 Social Security No. None

16 BIRTHPLACE (City) Chelsea, Mass.
(State or country)

17 NAME OF FATHER James O'Leary

18 BIRTHPLACE OF FATHER (City) Chelsea, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Veronica M. McCann

20 BIRTHPLACE OF MOTHER (City) Chelsea, Mass.
(State or country)

21 Informant George Roberts

(Address) 59 Crest Ave., Winthrop, Mass.

A TRUE COPY

ATTEST: Margaret H. Kane
(Registrar of City or Town where death occurred)

DATE FILED 9-14-1965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



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I.C.

Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **204**

Suffolk
(County)

Winthrop
(City or Town)

Mayflower Nursing Home
No. _____

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Edith B (Wolcott) McLaughlin**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(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, **2** months, _____ days. In place of residence, **60** years, _____ months, _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Sept 15 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **July 59** to **Sept. 15 1965**
I last saw him alive on **Sept. 15 1965** death is said to have occurred on the date stated above, at **10:45 P.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Arteriosclerotic Heart Disease**

Due To (b) _____

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 _____

(Signature) **Charles Liberman**, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) **WINTHROP, MASS** Date **9/15/65**

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Sept. 18 65**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop Mass**

Received and filed **SEP 16 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female**

9 COLOR **White**

10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)
(or) **WIFE of** **Waldo M McLaughlin**
(Husband's name in full)

12 AGE **89** Years **1** Months **1** Days
If under 24 hours
Hours _____ Minutes _____

13 Usual Occupation: **Housewife**
(Kind of work done during most working life)

14 Industry or Business: **At Home**

15 Social Security No. **None**

16 BIRTHPLACE (City) **Hartford**
(State or country) **Connecticut**

17 NAME OF FATHER **Arthur Wolcott**

18 BIRTHPLACE OF FATHER (City) **Hartford**
(State or country) **Connecticut**

19 MAIDEN NAME OF MOTHER **Julia Brace**

20 BIRTHPLACE OF MOTHER (City) **Hartford**
(State or country) **Connecticut**

21 Informant **Albert Shorley**
(Address)
172 Maple St Malden, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me **BEFORE** the burial or transit permit was issued:
Paul C Gaffney
(Signature of Agent of Board of Health or other)
Director of Public Health **Sept 16, 1965**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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 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 1 6 1035 PM

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PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

205

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LENA (POPKIN) TAUB

(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) Permanent Residence. No. ~~XXXXXX~~ 25 Almont StreetSt. ~~XXXXXX~~ Mattapan, Mass
(City or town and State)

Length of stay: In place of death.....years.....months 20.....days. In place of residence 10.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 9 21 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
June 10, 1965, to Sept 21, 1965
I last saw relative on Sept 20, 1965. Death is said to
have occurred on the date stated above, at 5:40 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral thrombosis

INTERVAL
BETWEEN
ONSET AND
DEATH

2 weeks

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS uremia, pneumonia
nephritis

Was autopsy performed? No

What test confirmed diagnosis? BUN urinalysis x-ray

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) H. B. Greenfield, M. D.

(Address) 447 Cambridge St
Mattapan

Date Sept 21, 1965

6 Workmens Circle Melrose
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT. 23, 1965

7 NAME OF FUNERAL DIRECTOR Robert Schlossberg
1267 Blue Hill Ave

ADDRESS Mattapan, Mass.

Received and filed SEP 21 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED W. dow
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of BENARD TAUB
(Husband's name in full)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 AT home

15 Social Security No. NONE

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER JACOB POPKIN

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER HANNAH COX

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)21 Informant FSADORE GOLD
(Address) 151 SAMOSET AVE QUINCYI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Gaffney (s)
(Signature of Agent of Board of Health or other)
Director of Public Health Sept 21, 1965
(Official Designation) (Date of Issue of Permit)

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:

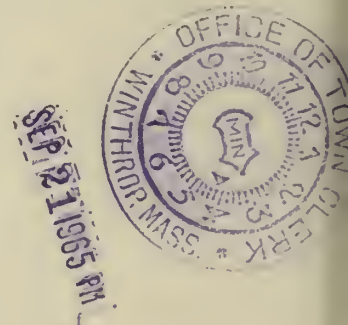
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



PLACE OF DELIVERY

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 NAME OF FETUS Baby Girl Magee
(if given)

3 DATE OF DELIVERY 9 24 '65
(Month) (Day) (Year)

Registered No. 206

The Commonwealth of Massachusetts

KEVIN H. WHITE

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.



4 SEX Male.....Female.....Undetermined.....

5 COLOR (if determined) wh.....

6 THIS BIRTH (Check one)
Single.....X.....Twin.....Triplet.....

7 IF MULTIPLE BIRTH, BORN:
1st.....2nd.....3rd.....

8 FATHER
FULL NAME Gerald Magee

14 MOTHER
MAIDEN NAME Diane Rupp

PRESENT NAME Diane Magee

9 RESIDENCE, NO. 62 Locust STREET
CITY OR TOWN Winthrop STATE Mass.

15 RESIDENCE, NO. 62 Locust St STREET
CITY OR TOWN Winthrop STATE Mass.

10 COLOR OR RACE wh..... 11 AGE AT TIME OF THIS DELIVERY 21 (Years)

16 COLOR OR RACE wh..... 17 AGE AT TIME OF THIS DELIVERY 18 (Years)

12 PLACE OF BIRTH Messiner, N.Y.
(City or Town) (State or country)

18 PLACE OF BIRTH Winthrop Mass.
(City or Town) (State or country)

13 OCCUPATION Carpenter

19 INFORMANT GERALD MAGEE

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) ONE

(a) How many children are now living? ONE

(b) How many children were born alive, but are now dead? NONE

(c) How many previous fetal deaths of ANY gestation age? NONE

21 LENGTH OF PREGNANCY completed weeks 40

22 Weight Lb. 8 Oz. -
OF FETUS (or Grams)

23 WHEN DID FETUS DIE?
Before During Labor or Delivery Unknown

24 AUTOPSY Yes No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Multiple twists of umbilical Cord

Due To (b) Cord

Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

26 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT 27 1965

27 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS 210 WINTHROP ST WINTHROP

Received and filed SEP 27 1965

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 8:05 PM., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
Maurice Traubstein, Jr. M.D.
MAURICE TRAUBSTEIN, JR. M.D.
(PRINT OR TYPE NAME)

Address B BARTLETT RD. Date 9/24 1965
WINTHROP, MASS

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Paul C Goffney (B)
(Signature of Agent of Board of Health or other)
Director of Public Health 9/27/65
(Official Designation) (Date of Issue of Permit)

In giving
CAUSE OF
FETAL DEATH

to not enter
more than one
use for each
of (a), (b)
and (c)

al or maternal
dition causing
al death (do
use such
ns as stillbirth
prematurity.)

al and/or mal-
al conditions,
ny, which gave
e to above
se (a), stating
e underlying
se last. →

ditions of fetus
mother which
y have contrib-
d to fetal
th, but, in so
as is known,
e not related
cause given
(a). →

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.

FORM R-301

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. CC056

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Elizabeth Steele
(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) Permanent Residence. No. Sturgis St. Winthrop, Massachusetts

(City or town and State)

Length of stay: In place of death, years, month, 7 days. In place of residence, 5 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 9, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That deceased died on
June 3, 1965 to June 9, 1965
last saw her alive on June 9, 1965, death is said to

have occurred on the date stated above, at m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Arteriosclerotic Heart Disease

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS
Fractured right Hip
Sustained by fall in
Nursing Home

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

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date June 9, 1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 12 1965

7 NAME OF FUNERAL DIRECTOR MAURILE W. MIRBY

ADDRESS 210 WINTHROP ST
WINTHROP

Received and filed JUN 15 1965

William J. Kane
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of JOHN H. STEELE
(Husband's name in full)12 AGE 93 Years Months Days 13 Usual Occupation HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. NONE

16 BIRTHPLACE (City), PICTON
(State or country) NOVA SCOTIA

17 NAME OF FATHER GEORGE S. PARVET

18 BIRTHPLACE OF FATHER (City) DETROIT
(State or country) MICH.

19 MAIDEN NAME OF MOTHER ISABELLE MACDONALD

20 BIRTHPLACE OF MOTHER (City) JUDICH
(State or country) NOVA SCOTIA

21 Informant MRS JOSEPH JONES

(Address) 35 COURT RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Michael A. Kane
(Signature of Agent of Board of Health or other)C10202 June 11, 1965
(Official Designation) (Date of Issue of Permit)This does not mean
mode of dying,
as heart failure,
hemiplegia, etc. It means
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
cause condition given
(a).

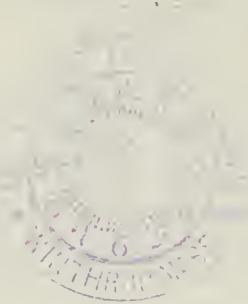
Medical Examiner to Counter Sign

JUN 13 1965

General Director
Please use only
BLACK Ink.

A TRUE COPY ATTEST:

Wm. H. Kance
City Regist



OCT 13 1865 AM

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

208

Suffolk

(County)

Brighton

(City or Town)

St. Elizabeths Hospital

No.

STANDARD

CERTIFICATE OF DEATH

Registered No. 00061

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles J. Murphy
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR 1 NO(a) Residence, No. 84 Taft Ave St. Winthrop Mass
(Usual place of abode) (City or town and State)

Length of stay: In place of death years 1 months 10 days. In place of residence 11 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 10 1965
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
April 22, 1965 to June 10, 1965
I last saw him live on June 10, 1965 death is said to
have occurred on the date stated above, at 1:35 P.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive Heart Failure

(b) Arteriosclerotic Heart Disease

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Coronary Artery Disease

Was autopsy performed?

What test confirmed diagnosis? Thoracentesis

5 Was disease or injury in any way related to occupation of deceased?
If so, specify NO

(Signature) Paul A. Melillo M.D. M. D.

(Address) St Elizabeths Hosp Date June 10, 1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 14 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY
210 WINTHROP ST
ADDRESS WINTHROP

Received and filed JUN 15 1965 19

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED11 If married, widowed, or divorced
HUSBAND of NATHALEEN MCCARTHY
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 73 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation BUSINESS AGENT
(Kind of work done during most of working life)

14 Industry or Business TEAMSTERS UNION

15 Social Security No. 016-07-1406
16 BIRTHPLACE (City) SOMERVILLE
(State or country) MASS

17 NAME OF FATHER CHARLES MURPHY

18 BIRTHPLACE OF FATHER (City) SOMERVILLE
(State or country) MASS

19 MAIDEN NAME OF MOTHER MARGARET (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) SOMERVILLE
(State or country) MASS21 Informant MRS NATHALEEN MURPHY
(Address) 84 TAFT AVE WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Michael A. Kane
(Signature of Agent of Board of Health or other)

C10203

(Official Designation)

June 11, 1965
(Date of Issue of Permit)

V.B.V.

A TRUE COPY ATTEST:

FORM R-301

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City Regist.



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OUT - OF - TOWN

SUFFOLK
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EAST BOSTON.
(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

209

STANDARD
CERTIFICATE OF DEATHRegistered No. 10263

No. 245 COLUMBUS NURSING HOME (If death occurred in a hospital or institution,
400 SARATOGA ST EAST BOSTON. St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MATILDA M BEATON (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) Permanent Residence. No. 333 REVERE St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death, 4 years, 4 months, 4 days. In place of residence, 4 years, 4 months, 4 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 1963 to June 16 1965

I last saw her alive on June 16 1965, death is said to have occurred on the date stated above, at 11:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Ovary 10 mos

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis Clinical, Pathological

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 6/16/1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 19 1965

7 NAME OF FUNERAL DIRECTOR MAURILE W WIRBY

ADDRESS WINTHROP

Received and filed JUN 22 1965

William J. Kane
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of ALBERT J BEATON
(Husband's name in full)

12 AGE 75 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No.

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

17 NAME OF FATHER UNKNOWN

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant ALBERT J BEATON
(Address) 233 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)

L 10432 6-18-65
(Official Designation) (Date of Issue of Permit) V.B.

A TRUE COPY ATTEST:

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Widow J. Lane.
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OUT - OF - TOWN

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(County)

BRIGHTON

(City or Town)

PLACE OF DEATH

No. ST. ELIZABETH'S HOSPITAL

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. 00525

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOHN MC CARTHY

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) 16

(a) Residence. No. 815 SHIRLEY

(Usual place of abode)

St. WINTHROP, MASS.

(City or town and State)

Length of stay: In place of death.....years.....months26days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 24, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
MAY 30, 1965, to JUNE 24, 1965I last saw him alive on JUNE 24, 1965, death is said tohave occurred on the date stated above, at 9:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF LUNGINTERVAL
BETWEEN
ONSET AND
DEATH

?

(b) Due To

(c) Due To

(c) Due To

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NoWhat test confirmed diagnosis? X-RAYS5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) Ralph M. Porter, M.D. M. D.

(Print or Type Name)

(Address) ST. ELIZ. HOSP. Date JUNE 24, 1965

ST. JOSEPH WEST ROXBURY

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL JUNE 28, 19657 NAME OF FUNERAL DIRECTOR John J. Brown, S.N.ADDRESS 15 West Main St. MarlboroReceived and filed JUN 29 1965 19.

William J. Kaine
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MALE WHITE

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Widowed

11 If married, widowed, or divorced

HUSBAND of MARY DRISCOLL

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

76

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

POST OFFICE

(Kind of work done during most of working life)

14 Industry

or Business

U.S. GOVERNMENT

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

BOSTON

MASS

17 NAME OF

FATHER

JOHN MC CARTHY

18 BIRTHPLACE OF

FATHER (City)

IRELAND

(State or country)

19 MAIDEN NAME

OF MOTHER

MARY MCURHAN

20 BIRTHPLACE OF

MOTHER (City)

IRELAND

(State or country)

21 Informant

JERIMIDH MCCARTHY SON

(Address)

24 EAST END ROAD

MARLBORO, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued;

Joseph J. Kaine C20682
(Signature of Agent of Board of Health or other)

June 25 1965

(Official Designation)

(Date of Issue of Permit)

V.B. ✓

3 1965

TRUE COPY ATTEST:

Wick

TRUE COPY ATTEST:

OCT 13 1965 AM

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

211
06843

Registered No.

PLACE OF DEATH
SUFFOLK
(County)
BOSTON
(City or Town)STANDARD
CERTIFICATE OF DEATH

Massachusetts General Hospital BAKER MEMORIAL

No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME MARY M MARTIN (KINSELLA)
(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) Permanent Residence. No. 7 Maryland Ave St. Winthrop Mass
(City or town and State)

Length of stay: In place of death years months days. In place of residence 8 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 2 1965
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from June 18 1965 to July 2 1965

I last saw her alive on July 2 1965 death is said to have occurred on the date stated above, at 1039 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Mitral & Aortic Stenosis 20yrs

(b) Rheumatic Heart Disease 30yrs

(c) OTHER SIGNIFICANT CONDITIONS Ventricular Fibrillation 3hrs

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

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D.

(Print or Type Name)

(Address) Asst. Dir. Mass. Gen'l. Hosp. Date July 2, 1965

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 6 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. NIBBY

ADDRESS 20 WINTHROP ST. WINTHROP

Received and filed JUL 1 1965

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of WILLIAM J. MARTIN (Husband's name in full)

12 AGE 45 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation HOME MAKER (Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No.

16 BIRTHPLACE (City) BOSTON (State or country) MASS

17 NAME OF FATHER LAWRENCE KINSELLA

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER ANNIE BELHARRY

20 BIRTHPLACE OF MOTHER (City) BOSTON (State or country) MASS

21 Informant WILLIAM J. MARTIN

(Address) 7 Maryland Ave WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transfer permit was issued:

Michael A. Kane (Signature of Agent of Board of Health or other)

C. 11026 JUL 5 1965 (Official Designation) (Date of Issue of Permit)

e filed for burial permit
with Board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEPRINT OR TYPE
USE OR CAUSES
OF DEATHdo not enter
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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 complica-
tions which caused
the death.Conditions, if any,
which gave rise to
above cause (a),
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lying cause last.Conditions contrib-
uting to death but not
related to the terminal
case condition given
(a).

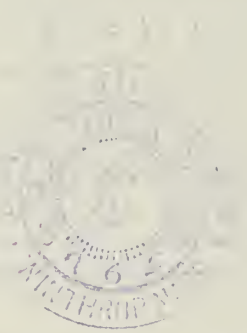
13 1965

Federal Directors
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10M-5-64-938000

A TRUE COPY ATTEST:

William H. Hare.
Notary Public



OCT 13 1935 AM

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Massachusetts General Hospital BAKER MEMORIAL

No.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 66782

2 FULL NAME MR. Vincent J. English
(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, No
{ if so specify WAR)

(a) Permanent Residence. No. 91 FAUN BAR Avenue, Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death years months 15 days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 3 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 15, 1965, to July 3, 1965.
I last saw him alive on July 3, 1965, death is said to
have occurred on the date stated above, at 8:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Herniation of Cerebellar

Due To tongil

(b) Metastatic Carcinoma of

Due To Brain

(c) Carcinoma of Ovary

OTHER SIGNIFICANT CONDITIONS Metastatic Carcinoma

Was autopsy performed? yes Right Lung Mos.

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify CC Play

(Signature) Charles L. Cleary, M.D.

(Address) Asst. Dir., Mass. Gen'l Hosp. Date July 3 1965

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 7 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St. Winthrop

Received and filed JUL 7 1965 19

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced, Mary V. Rodden
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 72 6 4
Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation Fireman
(Kind of work done during most of working life)

14 Industry or Business City of Everett

15 Social Security No. 023-20-3090

16 BIRTHPLACE (City, State or country) East Boston, Mass.

17 NAME OF FATHER Tobias English

18 BIRTHPLACE OF FATHER (City, State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Ellen Fogarty

20 BIRTHPLACE OF MOTHER (City, State or country) Newfoundland

21 Informant Mrs. Mary English

(Address) 91 Faun Bar Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

W. J. Kane C 11009
(Signature of Agent of Board of Health or other)

July 5 1965
(Official Designation) (Date of Issue of Permit)

TRUE COPY ATTACHED

William J. Lane.

OCT 1 2 1865 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Melrose
 (City or Town making this return)

COPY OF
 CERTIFICATE OF DEATH

Registered No. 913

Middlesex

(County)

Melrose

(City or Town)

No. Middlesex Fells Nursing Home

{(If death occurred in a hospital or institution,
 St. give its NAME instead of street and number)}

2 FULL NAME Elizabeth Young

(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) Permanent Residence. No. 41 Pleasant Park Road St. Winthrop, Mass.
 (Usual place of abode) (City or town and State)

Length of stay: In place of death.....year 3.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 2, 1965
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 65 to September 2, 1965
 I last saw her alive on September 2, 1965, death is said to have occurred on the date stated above, at 5:50 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Bladder 18 mo

(b) Due To

(b)

(c) Due To

(c)

OTHER
 SIGNIFICANT
 CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Path Biopsy

5 Was disease or injury in any way related to occupation of deceased? No
 If so, specify

(Signature) Edward C. Parkhurst, M. D.

(Address) Boston, Mass. Date Sept. 2, 1965

6 Winthrop Winthrop, Mass.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 4, 1965

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed 10-11-65 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 Single
 DIVORCED
 UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years 1 Months 24 Days If under 24 hours
 Hours Minutes

13 Usual Occupation: Housekeeper
 (Kind of work done during most of working life)

14 Industry or Business: Private Home

15 Social Security No. 016-26-8298

16 BIRTHPLACE (City) Unable to obtain
 (State or country) Scotland

17 NAME OF FATHER James Young

18 BIRTHPLACE OF FATHER (City) Unable to obtain
 (State or country) Scotland

19 MAIDEN NAME OF MOTHER Elizabeth Longmuir

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
 (State or country) Scotland

21 Informant Daniel McLean

(Address) 53 Beals Street, Winthrop, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED September 7, 1965

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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



OCT 11 1965 AM

The Commonwealth of Massachusetts

Norfolk

(County)

Wrentham

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Wrentham

(City or Town making this return)

 COPY OF
 CERTIFICATE OF DEATH

Registered No. 211

No. Sheldonville Nursing Home

 (If death occurred in a hospital or institution,
 St. give its NAME instead of street and number)

 2 FULL NAME Alice Mary Williams
 (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) Permanent Residence. No. 356 Pleasant St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, 2 years, months, days. In place of residence, 25 years, months, days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH September 25, 1965
 (Month) (Day) (Year)

 I HEREBY CERTIFY That I attended deceased from
 Aug. 5, 1965, to Sept. 25, 1965
 I last saw her alive on Sept. 24, 1965, death is said to

have occurred on the date stated above, at 2.15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia 2 days

Due To Cerebral vascular accident months

(b) Arteriosclerosis years

(c) Congestive heart failure

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

(Signature) Craig D. Hobson, M. D.

(Address) 20 Orne, N. Attleboro 9-25-65

(City or Town)

6 Holy Cross Cemetery, Malden, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 28, 1965

7 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons, Inc.

ADDRESS Boston, Mass.

Received and filed OCT 22 1965

(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 DIVORCED UNKNOWN Single

11 If married, widowed, or divorced HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 76 Years 8 Months 27 Days If under 24 hours Hours Minutes

13 Usual Occupation: Retired

(Kind of work done during most of working life)

14 Industry or Business: Boston Advertiser

15 Social Security No. 029-01-4582

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER Andrew B. Williams

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Margaret A. Murphy

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Miss Jane Williams

(Address) 59 Commercial Wharf, Boston

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED September 27, 1965

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 occurred 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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE May 23, 1917

DATE OF DISCHARGE May 24, 1920

RANK, RATING Chief Yeoman

ORGANIZATION AND OUTFIT Navy

SERVICE NUMBER 1642757

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For burial permit
and of Health
Agent.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 215

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 132 GrandView Ave

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Eleanor S (Fitzgerald) Bidmead
(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) Permanent Residence. No. 132 GrandView Ave
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death. 5 months. 30 days. In place of residence. 30 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 1 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Dec 1 46 to Oct 1 1965
I last saw him alive on Oct 1 1965 death is said to
have occurred on the date stated above, at 1:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure yrs.

(b) Due To Rheumatic Heart Disease 19 yrs

(c) Due To Constrictive pericarditis yrs

OTHER SIGNIFICANT CONDITIONS mitral valvuloplasty

Was autopsy performed? No

What test confirmed diagnosis X-Rays, Surgery

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) H.B. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Winthrop Ave, Winthrop, Mass. Date Oct 2 1965

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 4 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed OCT 4 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)
Clifford D Bidmead

(or) WIFE of (Husband's name in full)

12 AGE 64 Years 3 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. None

16 BIRTHPLACE (City) Brookline Mass.
(State or country)

17 NAME OF FATHER Thomas M Fitzgerald

18 BIRTHPLACE OF FATHER (City) XXXXXXXX
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Ellen Cahill

20 BIRTHPLACE OF MOTHER (City) XXXXXXXX
(State or country) Ireland

21 Informant Clifford D Bidmead
132 Grandview Ave. Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Giffney (S)

(Signature of Agent of Board of Health or other)

Director of Public Health Oct 4, 1965
(Official Designation)

(Date of Issue of Permit)

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 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 4 1965 PM



R-303

burial permit
of Health
Agent.

WHILE 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.

100W-5-611-938000

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

(City or Town making this return)

Registered No. 216

No. Winthrop Community Hospital (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME GUY H. LOTHROP
(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) 10

(a) Permanent Residence. No. 104 Court Road, Winthrop
(City or town and State)

Length of stay: In place of death years 1 months 7 days. In place of residence 60 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 2, 1965
(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.)

ARTERIOSCLEROTIC HEART
DISEASE.

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?

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.

(Address) Boston (Print or Type Name)

7 Holy Hood Place of Burial or Cremation 10/2 19 65
(City or Town)

DATE OF BURIAL Oct 5 19 65

8 NAME OF FUNERAL DIRECTOR Maurice H. Kirby

ADDRESS 210 Winthrop St

Received and filed 19

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

12 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 AGE 22 Years 5 Months 5 Days If under 24 hours
Hours Minutes

14 Usual Occupation: Salesman
(Kind of work done during most of working life)

15 Industry or Business: Candy Salesman
Candy Salesman 210-9445

16 Social Security No. not known
17 BIRTHPLACE (City) Chelsea Mass
(State or country)

18 NAME OF FATHER Henry Lothrop

19 BIRTHPLACE OF FATHER (City) Hyannisport
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Mary Harper

21 BIRTHPLACE OF MOTHER (City) Not known
(State or country)

22 Informant (Address) Lillian Lothrop
104 Court Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Giffney (B1)
(Signature of Agent of Board of Health or other)

Director of Public Health Oct 4 1965
(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



OCT 4 1965 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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 217

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 George Reese

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) 10

(a) Permanent Residence. No. 28 Jefferson St., Winthrop
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 37 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 2 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from December 1956 to Oct 2, 1965

I last saw him alive on Oct 1, 1965 death is said to have occurred on the date stated above, at 12:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) NEPHRO-SCLEROSIS & PARTIAL UREMIA
Due To ARTERIO-SCLEROTIC HEART
(b) WITH CONGESTIVE FAILURE
(c)

INTERVAL BETWEEN ONSET AND DEATH

15 DAYS

1 1/2 YRS

OTHER SIGNIFICANT CONDITIONS CHRONIC BRONCHITIS & EMPHYSEMA
CO. NARCOSIS

30 YRS
15 DAYS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL, EXPT. X-RAYS

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron H. King M. D.

(Print or Type Name) MYRON H. KING M.D.

(Address) 20 Pleasant St. Date 10/2/65

6 Winthrop Com. Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 5, 1965

7 NAME OF FUNERAL DIRECTOR Maurice H. Ruby

ADDRESS 210 Winthrop St. Winthrop

Received and filed Oct 3, 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED, WIDOWED, DIVORCED, UNKNOWN married

11 If married, widowed or divorced HUSBAND of Gene M. (Silvia) Reese
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 67 Years - Months - Days If under 24 hours Hours Minutes

13 Usual Occupation Stock man
(Kind of work done during most of working life)

14 Industry or Business: Brownfields manufacturing

15 Social Security No. 024-14-8508

16 BIRTHPLACE (City) East Boston Mass.
(State or country)

17 NAME OF FATHER George Reese

18 BIRTHPLACE OF FATHER (City) East Boston Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Emme Roulett

20 BIRTHPLACE OF MOTHER (City) East Boston Mass.
(State or country)

21 Informant Mrs. Gene M. Reese

(Address) 28 Jefferson St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney (3)

(Signature of Agent of Board of Health or other)

Director of Public Health Oct 4, 1965

(Official Designation) (Date of Issue of Permit) V.B.V.

FORM R-301

for burial permit
Ord of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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V.B.V.

65-939763

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.

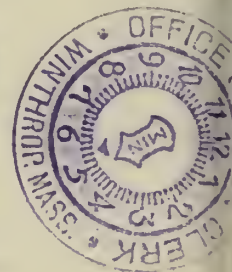
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

DEC 14 1965 PM



for burial permit
Board of Health
Agent.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 218

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 Joseph Gmari
(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. 59 WEST EAGLE

St. EAST BOSTON MASS
(City or town and State)

Length of stay: In place of death 1 years 4 months days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 3 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan. 1965 to Oct. 3 1965
I last saw him alive on Sept. 20, 1965, death is said to
have occurred on the date stated above, at 12:24 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

(b) arteriosclerosis -

(c)

OTHER SIGNIFICANT CONDITIONS Parkinson's Disease

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

(Signature) Joseph Gmari M. D.

(Print or Type Name) JOSEPH G. GRIFFIN

(Address) 194 Washington St. Wintrop Date Oct 3 1965

6 WOODLAWN EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT. 5, 1965

7 NAME OF FUNERAL DIRECTOR DIPIETRO & VAZZA

11 HENRY ST. EAST BOSTON
ADDRESS

Received and filed OCT 4 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of ROSE CAMMARATA
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 75 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation FREIGHT HANDLER (RETIRED)
(Kind of work done during most of working life)

14 Industry or Business WAREHOUSE

15 Social Security No. 028-01-5410

16 BIRTHPLACE (City) ITALY
(State or country)

17 NAME OF FATHER PETER AMARI

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER MARY D'ANGELO

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant ALBA DELOLLIS

59 WEST EAGLE ST. EAST BOSTON
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health Oct 4 1965
(Official Designation)

(Date of Issue of Permit)

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.

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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.



RECEIVED

burial permit
of Health
Agent.

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 219

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 Alexander Barnett

(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) Permanent Residence. No.

232 Shirley St.

Winthrop, Mass.

St. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....16.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 3 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Dec 7, 1960, to Oct 3, 1965I last saw him live on Sept 29, 1965 death is said to
have occurred on the date stated above, at 9:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To (b) arteriosclerotic heart disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS Diabetes Congestive heart failure Peripheral vascular disease

Was autopsy performed? No
What test confirmed diagnosis? X-Ray ECG.5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) H. B. Greenfield, M. D.

(Address) 47 Shirley St. Winthrop Date Oct 3, 1965

6 Beth Israel Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 4, 1965

7 NAME OF FUNERAL DIRECTOR Toref Funeral Serv. Inc.

ADDRESS 151 Washington Ave., Chelsea

Received and filed OCT 5 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married11 If married, widowed, or divorced
HUSBAND of Dora Goren
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 56 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Clerical Worker
(Kind of work done during most of working life)

14 Industry or Business General Electric, Lynn

15 Social Security No. 032-01-7201

16 BIRTHPLACE (City) Chicago, Illinois
(State or country)

17 NAME OF FATHER Harry Barnett

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Lillian Drossman

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Mrs. Dora Barnett (Wife)
(Address) 232 Shirley St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 10/4/65



SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

OCT - 5 1965 AM

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

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medical Examiner Dr. Luongo

burial permit
of Health
Agent.

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Med. Examiner notified - referred to Board of Health.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 48 BELLEVUE AVE

STANDARD CERTIFICATE OF DEATH

Registered No. 220

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME EMMA BUONO (Ciampa)
(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) Permanent Residence. No. 48 BELLEVUE AVE St. WINTHROP, MASS

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 1.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 5, 1965
(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 1:30 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
(b) to natural causes, probably
(c) due to chronic heart disease
on basis of history

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

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 10/5/1965

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT. 7, 1965

7 NAME OF FUNERAL DIRECTOR DIPIETRO VAZZA
11 HENRY ST, EAST BOSTON
ADDRESS

Received and filed OCT 6 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of LEOPOLD BUONO
(Husband's name in full)

12 AGE 55 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). BOSTON MASS.
(State or country)

17 NAME OF FATHER FRANK CIAMPA

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER ROSINA SALORENZO

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant LEOPOLD BUONO
48 BELLEVUE AVE, WINTHROP
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Hoffner (M.D.)
(Signature of Agent of Board of Health or other)
Director of Public Health 10/6/65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



OCT - 6 1965 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.

Burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No.

221

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

Isabella (Young) McLean

(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) Permanent Residence. No.

41 Pleasant Park Road

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....24 days. In place of residence.....42 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 9 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Jan. 22, 1953 to Oct. 9, 1965I last saw him live on Oct. 8, 1965, death is said to
have occurred on the date stated above, at 9:20 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

INTERVAL
BETWEEN
ONSET AND
DEATH

3 mos.

(b) Due To Arteriosclerotic heart disease

(c) Due To Generalized arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Parkin-
sons diseaseWas autopsy performed? no
What test confirmed diagnosis? clinical and lab.5 Was disease or injury in any way related to occupation of deceased?
If so, specify no

(Signature) M. Traustein, Jr., M. D.

(Print or Type Name)

(Address) 73 Bartlett Road, Date Oct. 9, 1965

Winthrop.

Winthrop

6 Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Oct. 11 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed OCT 11 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

F

9 COLOR

white

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widow

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William H McLean
(Husband's name in full)

12 AGE 85 Years 2 Months 21 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. 023-07-1603

16 BIRTHPLACE (City)
(State or country) Scotland

17 NAME OF FATHER James Young

18 BIRTHPLACE OF FATHER (City)
(State or country) Scotland

19 MAIDEN NAME OF MOTHER Elizabeth Longmuir

20 BIRTHPLACE OF MOTHER (City)
(State or country) Scotland

21 Informant Daniel McLean

(Address) 53 Beal St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Gaffney Jr.
(Signature of Agent of Board of Health or other)Director of Public Health Oct 11, 1965
(Official Designation) (Date of Issue of Permit)

V.B.V

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

OCT 11 1965 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

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. 000

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 325 Winthrop Street

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME LOUIS W. BELLI

(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, WW #1
if so specify WAR)}

(a) Residence, No. 325 Winthrop
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 32 years.....months.....days. In place of residence 32 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 12, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 18, 1964, to October 12, 1965.
I last saw him alive on October 12, 1965, death is said to
have occurred on the date stated above, at 6:10 P.M.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

Due To (b) Arteriosclerosis

Due To (c)

probably 1 hour.
5 years

OTHER SIGNIFICANT CONDITIONS Cerebral Thrombosis (old) 13 months

Was autopsy performed? no
What test confirmed diagnosis? physical findings

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 Name)

(Address) 27 Bennington St. Date October 13, 1965
Revere, Mass.

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 15, 1965

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave. Revere

Received and filed OCT 14 1965

(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 Teresa M. Poli
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 DATE OF BIRTH 5-9-92

13 AGE 73 Years 5 Months 3 Days If under 24 hours
Hours Minutes

14 Usual Occupation: Retired-Broker
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 031-05-0446

17 BIRTHPLACE (City) Boston
(State or country) Mass.

18 NAME OF FATHER George Belli

19 BIRTHPLACE OF FATHER (City) Italy
(State or country)

20 MAIDEN NAME OF MOTHER Eugenia C. Repetto

21 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

22 Informant Teresa M. Belli
(Address) 325 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:

Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health Oct 14 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V.B.V.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE..... 8/27/18
DATE OF DISCHARGE..... 12/9/18
RANK, RATING Priv.
ORGANIZATION AND OUTFIT..... Army
SERVICE NUMBER..... 4138472

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 1 4 1965 AM

For burial I permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 223

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)

2 FULL NAME David H. GARFIELD
(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) Permanent Residence. No. 24 DELANO AVE.
(Usual place of abode)

St. REVERE
(City or town and State)

Length of stay: In place of death 1 years 6 months days. In place of residence 15 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 16 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1964, to Oct. 16, 1965
I last saw him alive on Oct. 14, 1965 death is said to have occurred on the date stated above, at 2:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease

(b) Due To Generalized Arteriosclerosis

(c) Due To

OTHER SIGNIFICANT CONDITIONS Cerebral Arteriosclerosis

INTERVAL
BETWEEN
ONSET AND
DEATH

2 yrs.

4 yrs.

2 yrs.

Was autopsy performed? NO

What test confirmed diagnosis? Clin. & LAB.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) M. Traunstein, Jr. M. D.

(Address) 23 Bartlett Rd., WINTHROP, MASS. 01965

Date 10/16/65

6 PRIDE OF LYNN LYNN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT. 17, 1965

7 NAME OF FUNERAL DIRECTOR Louis Hymanson

ADDRESS LYNN, MASS.

Received and filed OCT 18 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of BERTHA GERBER
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 73 Years 7 Months 7 Days If under 24 hours Hours Minutes

13 Usual Occupation FURNITURE JOBBER
(Kind of work done during most of working life)

14 Industry or Business RETIRED

15 Social Security No. 01-14-4968

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER HARRY GARFINKLE

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER BESSIE RICKMAN

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

21 Informant BERTHA GARFIELD - WIFE
(Address) 24 DELANO AVE. REVERE

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Sullivan
(Signature of Agent of Board of Health or other)
Director of Public Health 10/17/65
(Official Designation) (Date of Issue of Permit)

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:

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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.

OCT 1 8 1965 PM

for burial permit
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FOR
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PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

View

No. Bay State Nursing Home

2 FULL NAME Rose Champagne Davis
(If deceased is a married, widowed or divorced woman, give also maiden name.)

X (a) Residence. No. 8 Elmwood Ct.
(Usual place of abode)

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

Registered No. 224

Length of stay: In place of death. 2 years. 2 months. 35 days. In place of residence. 35 years. 2 months. 35 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 20, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct. 19, 55, to Oct. 20, 1965.

I last saw her alive on Oct. 19, 1965, death is said to
have occurred on the date stated above, at 7:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease

Due To Generalized Arteriosclerosis

(b) 80 yrs.

OTHER SIGNIFICANT CONDITIONS Brounchial Asthma

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

(Signature) Charles Liberman M. D.

(Address) WINTHROP, MASS. Date 10/20/1965

6 Temple Israel Wakefield
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 22, 1965

7 NAME OF FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed OCT 21 1965

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

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

st. Winthrop
(City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of David Robert Davis
(Husband's name in full)

12 AGE 84 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. 022-28-0631

16 BIRTHPLACE (City) Germany
(State or country)

17 NAME OF FATHER Adolph Champagne

18 BIRTHPLACE OF FATHER (City) Germany
(State or country)

19 MAIDEN NAME OF MOTHER Dorothea Lazarus

20 BIRTHPLACE OF MOTHER (City) Germany
(State or country)

21 Informant Mrs. Miriam Hurvins
(Address) 8 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:

Paul C. Gaffney
(Signature of Agent of Board of Health or other)
Director of Public Health Oct 21, 1965
(Official Designation) (Date of Issue of Permit)

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:

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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.)

50M-5-64-938000

PLACE OF DEATH

Middlesex

(County)

Bedford

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 225

No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME SELMA (COHEN) ELKIN (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 2

(a) Permanent Residence. No. 37 Myrtle Street St. Winthrop, Massachusetts (City or town and State)

Length of stay: In place of death. 1 years 3 months 6 days. In place of residence. years months days.

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH	October 21 1965 (Month) (Day) (Year)	9 SEX	10 COLOR
		Female	White
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.)	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN		Married
Syncope during acute asthmatic episode. (Sudden death)	12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Frank Elkin (Husband's name in full)		
5 Accident, suicide, or homicide (specify)	13 AGE 40 Years 7 Months 14 Days	If under 24 hours Hours Minutes	
Date and hour of injury 19	14 Usual Occupation: Housewife	(Kind of work done during most of working life)	
IF ACCIDENTAL, was injury causally related to the death? Where did Injury occur? (City or town and State)	15 Industry or Business:		
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)	16 Social Security No. 024-18-0208		
Manner of Injury (How did injury occur?)	17 BIRTHPLACE (City) Boston	(State or country) Massachusetts	
Nature of Injury	18 NAME OF FATHER Nathan Cohen		
While at work? Was autopsy performed? Yes	19 BIRTHPLACE OF FATHER (City) Could not be learned	(State or country) Russia	
6 Was disease or injury in any way related to occupation of deceased? No	20 MAIDEN NAME OF MOTHER Frances Miller		
If so, specify	21 BIRTHPLACE OF MOTHER (City) Could not be learned	(State or country) Russia	
(Signed) LEROY P. HOUCK, M. D.	22 Informant VA Hospital Records		
(Address) Concord, Mass. Date 10-21-65 19	Address Bedford, Massachusetts		
7 Sharon Memorial Park, Sharon, Massachusetts	A TRUE COPY		
Place of Burial or Cremation. (City or Town)	ATTEST: Donald V. Pfeiffer	(Registrar of City or Town where death occurred)	
DATE OF BURIAL October 22, 1965 19	DATE FILED OCT 25 1965 19		
8 NAME OF FUNERAL DIRECTOR Stanetsky Funeral Home			
ADDRESS 1505 Blue Hill Ave., Boston, Mass.			
Received and filed 19			
(Registrar of City or Town where deceased resided)			

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 5-31-45

DATE OF DISCHARGE 8-20-46

RANK, RATING Seaman 1/C

ORGANIZATION AND OUTFIT U.S. Navy

SERVICE NUMBER 7490359

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60126155

For burial permit
Board of Health
Agent.

DUCTIONS
FOR
CERTIFICATE

OR TYPE
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **226**

Suffolk
(County)
Winthrop
(City or Town)
No. **129 River Road**



2 FULL NAME **Etta (Nettie) V (Campbell) Dickson**
(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

(a) Residence. No. **129 River Road** St. **Winthrop**
(Usual place of abode) (City or town and State)

Length of stay: In place of death. **50** years. **50** months. **50** days. In place of residence. **50** years. **50** months. **50** days.

MEDICAL CERTIFICATE OF DEATH	
3 DATE OF DEATH	October 22 1965 (Month) (Day) (Year)
4 I HEREBY CERTIFY, That I attended deceased from October 19 59 to Oct 22 1965 , 19 65 I last saw him alive on Oct 21 1965 death is said to have occurred on the date stated above, at 4:45 AM .	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE	
(a)	myocardial infarction
(b)	arteriosclerotic heart disease
(c)	
OTHER SIGNIFICANT CONDITIONS Had many attacks angina pectoris	

INTERVAL
BETWEEN
ONSET AND
DEATH

10 min.

yrs.

Was autopsy performed? **No**
What test confirmed diagnosis? **Ecg's**

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify

(Signature) **H. B. Greenfield**, M. D.
447 Shirley St (Print or Type Name)
(Address) **Winthrop** Date **Oct 22 1965**

6 **Winthrop** **Winthrop**
Place of Burial or Cremation (City or Town)
DATE OF BURIAL **Oct 25 1965**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop, Mass**
OCT 25 1965

Received and filed **OCT 25 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS		
8 SEX Female	9 COLOR Colored	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Harry H Dickson (Husband's name in full)		
12 AGE 88 Years 6 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. 029-05-8252		
16 BIRTHPLACE (City) Boston (State or country) Mass.		
17 NAME OF FATHER John Campbell		
18 BIRTHPLACE OF FATHER (City) Unable to obtain (State or country)		
19 MAIDEN NAME OF MOTHER Rachel McCleary		
20 BIRTHPLACE OF MOTHER (City) England (State or country)		

21 Informant **Everett A Hazel**
129 River Road
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation)
Oct 25 1965 (Date of Issue of Permit)

A TRUE COPY ATTEST:

V-P

medical examiner Dr. L. L. L. - not filed

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

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

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 ABRAHAM FREDMAN
(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) Permanent Residence. No. 311a Shirley St.,
St. Winthrop Mass.
(City or town and State)

Length of stay: In place of death.....years.....months.9.....days. In place of residence.34.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 22 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN. 1965, to Oct. 22, 1965
I last saw him alive on Oct. 22, 1965, death is said to
have occurred on the date stated above, at 10:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastric Hemorrhage, Acute. 24 hrs.

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Herpes Zoster 4 wks.

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

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 10/22/65
(Print or Type Name)

T.I. of Winthrop Cem. Everett Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 24th 1965

7 NAME OF FUNERAL DIRECTOR Levine Chapel Inc
470 Harvard St Brookline Mass
ADDRESS

Received and filed OCT 22 1965 19

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Gussie Farber
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 80 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation self employed (Retired)
(Kind of work done during most of working life)

14 Industry or Business Delicatessen

15 Social Security No. UNKNOWN

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER MORRIS FREDMAN

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER SHIFRA (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Gussie Fredman

311a Shirley St Winthrop Mass.
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney, Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health 10/24/65
(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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No.

228

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 PENNELL, ADDIE E. (Haskell)
(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) Permanent Residence. No. 35 Thornton Park., St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, years, months, 21 days. In place of residence, 15 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 23 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan 1965 to Oct 23 1965
last saw him alive on Jan 22 1965, death is said to

have occurred on the date stated above, at 3:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

INTERVAL
BETWEEN
ONSET AND
DEATH

(b) Carcinoma of ovary

(c)

OTHER SIGNIFICANT CONDITIONS
Arteriosclerosis

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

(Signature) Joseph J. ... M. D.

(Print or Type Name) Joseph J. ...

(Address) 194 Washington St. Date 10-23-65

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 26 1965

7 NAME OF FUNERAL DIRECTOR Ernest Plagiano

ADDRESS 147 Winthrop St Winthrop

Received and filed OCT 25 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED married
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of John C. Pennell
(Husband's name in full)12 AGE 72 Years 1 Months 9 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) ... Mass
(State or country)

17 NAME OF FATHER Everett S Haskell

18 BIRTHPLACE OF FATHER (City) ... Maine
(State or country)

19 MAIDEN NAME OF MOTHER Aroline Haskell

20 BIRTHPLACE OF MOTHER (City) ... Maine
(State or country)21 Informant John C. Pennell
(Address) 35 Thornton Park WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Sweeney
(Signature of Agent of Board of Health or other)Director of Public Health 10/24/65
(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 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.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 229

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 Mrs. Pasqualina Cataldo (DiPasquale)
(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) Permanent Residence. No. 7 Jeffries St. East Boston, Mass.
(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 October 24 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 1963, to October 24 1965

I last saw her alive on October 24, 1965, death is said to have occurred on the date stated above, at 1 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PNEUMONIA
INTERVAL BETWEEN ONSET AND DEATH 2 days

(b) Due To CEREBRAL HEMORRHAGE 14 R.

(c) Due To ARTERIO SCLEROTIC HEART DISEASE 25 yrs.

OTHER SIGNIFICANT CONDITIONS Hypertension

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(Signature) Peter J. Ferrino, M. D.
PETER J. FERRINO

(Address) 21 BENNINGTON STREET Date Oct 24 1965

6 Holy Cross, Malden, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 27, 1965

7 NAME OF FUNERAL DIRECTOR TULLO Russo Funeral Service

ADDRESS 306 Main St. Medford, Mass.

Received and filed OCT 26 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced HUSBAND of Sabino Cataldo (Give maiden name of wife in full)

(or) WIFE of Sabino Cataldo (Husband's name in full)

12 AGE 83 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. none

16 BIRTHPLACE (City) Italy (State or country)

17 NAME OF FATHER Pasquale Di Pasquale

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER (unknown)

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant Mrs. Jenny Lombardi (daughter)

(Address) 7 Jeffries 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:

Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health (Official Designation)

Oct 26, 1965 (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.



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PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. ~~26 Stungis St.~~ Bay View Nursing Home

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John H. Kelleher
(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. 15 Palmyra St.
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death, years 6 months 30 days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 31, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1960 to Oct. 31, 1965.

I last saw him alive on Oct. 31, 1965, death is said to have occurred on the date stated above, at 12:10 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Arteriosclerosis 3yrs.

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To

(b)

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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 10/31/1965

6 St. Marys's Randolph, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 3, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed NOV 1 1965 19.

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 230

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced HUSBAND of Mary Etta Visall
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 85 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 Building Supplies

15 Social Security No. 023-20-2516

16 BIRTHPLACE (City) Randolph, Mass
(State or country)

17 NAME OF FATHER Dennis Kelleher

18 BIRTHPLACE OF FATHER (City) Randolph, Mass
(State or country)

19 MAIDEN NAME OF MOTHER Rose H. Riley

20 BIRTHPLACE OF MOTHER (City) Randolph, Mass
(State or country)

21 Informant Robert Kelleher

(Address) 66 Wickey Ave Westbury L.I.

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)

Director of Public Health Nov 1-65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

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:

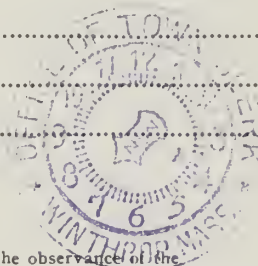
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.

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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.



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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

Registered No. 231

Suffolk
(County)

Winthrop
(City or Town)



STANDARD CERTIFICATE OF DEATH

26xSturgisxStreet Bay View Nursing Home
No. (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

Noting Address 26 STURGIS ST

2 FULL NAME RACHEL B. MORRISON
(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. 26xSturgisxSt 6 Palmyra St., St. (City or town and State)
(Usual place of abode)

Length of stay: In place of death 2 years 6 months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCT 31 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from MAR 20 1953 to OCT 31 1965
I last saw her alive on OCT 31 1965 death is said to have occurred on the date stated above, at 8:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCCLUSION

(b) ARTERIO-SCLEROTIC HEART DIS 5 YRS

(c) GENERAL ARTERIO-SCLEROSIS

OTHER SIGNIFICANT CONDITIONS ANTHRAXIS 5 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

(Signature) Myron H. Kinn, M. D.

(Address) 121 Pleasant St Winthrop, Mass Date 10/31 1965

(Print or Type Name)

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 2, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed NOV 3 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Arthur C. Morrison (Husband's name in full)

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

16 BIRTHPLACE (City) Cincinnati (State or country) Ohio

17 NAME OF FATHER John Brown

18 BIRTHPLACE OF FATHER (City) (State or country) Germany

19 MAIDEN NAME OF MOTHER Sebilla Mohn

20 BIRTHPLACE OF MOTHER (City) (State or country) Ohio

21 Informant Walter Morrison

(Address) 41 Kealing Cir So Weymouth

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

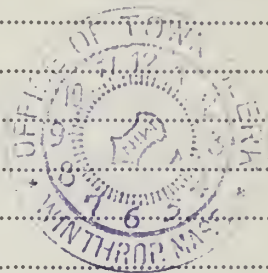
Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health Nov 1-65 (Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



NOV - 1 1965 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.

FORM R-301

OUT - OF - TOWN The Commonwealth of Massachusetts

SUFFOLK

(County)

BOSTON

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

232

STANDARD
CERTIFICATE OF DEATH

Registered No. 07500

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. Anne Martel

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. Bayview Nursing Home Sturgis St. Winthrop Mass.

(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 25, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 13, 1965, to July 25, 1965.

I last saw her alive on July 25, 1965, death is said to have occurred on the date stated above, at 4:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHOPNEUMONIA

(b) PERITONITIS

Due To
(c)

OTHER SIGNIFICANT CONDITIONS RETICULUM CELL SARCOMA MOS. WITH WIDESPREAD METASTASES

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

(Signature) Charles L. Cloy, M.D., M. D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date July 25, 1965

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 28, 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. HIRBY

ADDRESS 110 WINTHROP ST. WINTHROP

Received and filed JUL 27 1965

William J. Hane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE	9 COLOR WHITE	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED
-----------------	------------------	--

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of ALBERT F. MARTEL
(Husband's name in full)12 AGE 86 Years 9 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 AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) COUNTY CLAIPE
(State or country) IRELAND

17 NAME OF FATHER MICHAEL O'REGAN

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER BRIDGET DINAHUE

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant EUGENE J. MARTEL

(Address) 98 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)

A TRUE COPY ATTEST:

 e filed for burial permit
 with Board of Health
 or its Agent.

 INSTRUCTIONS
 FOR
 MEDICAL CERTIFICATE

 PRINT OR TYPE
 USE OR CAUSES
 OF DEATH

 do not enter
 more than one
 cause for each
 (a), (b) and (c)

 This does not mean
 a mode of dying,
 such as heart failure,
 pneumonia, etc. It means
 a disease, or complica-
 tions which caused
 death.

 Conditions, if any,
 which gave rise to the
 above cause (a),
 taking the under-
 lying cause last.

 Conditions contrib-
 uting to death but not
 related to the terminal
 disease condition given
 (a).

JUL 3 1965

General Director

Please use only

BLACK Ink.

24-5-64-938000

Jurisdiction Declined By Medical Examiner To Be Countersigned

OCT 13 1965 AM

PLACE OF DEATH

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

St. Elizabeth's Hospital

No.



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. **07686**

233

2 FULL NAME **JAMES DONOVAN**
 (First Name) (Middle Name) (Last Name)
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

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**

(a) Residence. No. **23 Almont St.,** St. **Winthrop, Mass.**
 (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.....**18**.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **July 28, 1965**
 (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.)

**Crushing injury of leg and foot
 followed by cardiac arrest.**

5 Accident, suicide, or homicide (specify) **Accident.**

Date and hour of injury **July 23, 1965**

IF ACCIDENTAL, was injury causally related to the death? **Yes.**

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? **Highway.**

(Specify type of place)

Manner of Injury **Caught in operating mechanism
 of disposal truck.**

Nature of Injury **Yes.**

While at work? **Yes.** Was autopsy performed **Yes.**

6 Was disease or injury in any way related to occupation of deceased? **Yes.**

If so, specify

(Signature) **Michael A. Luongo, M.D.**

(Print or type name)

(Address) **Boston** Date **7/28 65**

7 **WINTHROP** **WINTHROP**
 Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL **JULY 31** 19**65**

8 NAME OF FUNERAL DIRECTOR **MAURILE W. KIRBY**

ADDRESS **200 WINTHROP ST WINTHROP**

Received and filed **AUG 3 1965**

William J. Naves
 (Registrar)

A TRUE COPY ATTEST:

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 **ANNA I. PAGLIARULO**
 (Give maiden name of wife in full)

(or) WIFE of _____
 (Husband's name in full)

13 DATE OF BIRTH

14 AGE **53** Years.....Months.....Days If under 24 hours
 Hours.....Minutes

15 Usual Occupation: **LABORER**
 (Kind of work done during most of working life)

16 Industry or Business: **TOWN OF WINTHROP.**

17 Social Security No. _____

18 BIRTHPLACE (City) **NOVA SCOTIA**
 (State or country)

19 NAME OF FATHER **JOHN J. DONOVAN**

20 BIRTHPLACE OF FATHER (City) **NOVA SCOTIA**
 (State or country)

21 MAIDEN NAME OF MOTHER **SARAH McDONALD**

22 BIRTHPLACE OF MOTHER (City) **NOVA SCOTIA**
 (State or country)

23 Informant **MRS ANNA DONOVAN**
 (Address) **23 ALMONT 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) **11907** (Date of Issue of Permit) **7-30-65**

115. ✓

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



NOV 24 1965 AM

OUT - OF - TOWN

The Commonwealth of Massachusetts

234

FORM R-301

SUFFOLK

(County)

BOSTON

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. (7685

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 Mary F. Regan (LANE)
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

 (Was deceased a
 U. S. War Veteran,
 if so specify WARA NO.

 (a) Permanent Residence. No. 322 Pleasant Street St. Winthrop, Massachusetts
 (City or town and State)

Length of stay: In place of death years months 2 days. In place of residence 37 years months days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH July 28, 1965
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY That I attended deceased from
 July 27, 1965, to July 28, 1965

I last saw her alive on July 28, 1965 death is said to

have occurred on the date stated above, at 3:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) INTestinal HEMORRHAGE

(b) Due To DIVERTICULOSIS OF COLON

(c) Due To

OTHER SIGNIFICANT CONDITIONS FATTY DEGENERATION OF HEART

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

(Signature) Charles L. Clay, M.D.

 Charles L. Clay, M.D.
 (Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date July 28, 1965

 6 WINTHROP WINTHROP
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 31, 1965

7 NAME OF FUNERAL DIRECTOR MARIE W. KIRBY

ADDRESS 320 WINTHROP ST WINTHROP

Received and filed AUG 3 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE

9 COLOR WHITE

 10 SINGLE (write the word)
 MARRIED
 WIDOWED
 DIVORCED
 UNKNOWN WIDOWED

11 If married, widowed, or divorced

 HUSBAND of (Give maiden name of wife in full)
 (or) WIFE of THOMAS L. REGAN
 (Husband's name in full)

 12 AGE 65 Years Months Days
 13 Usual Occupation HOUSE WIFE
 (Kind of work done during most of working life)

 If under 24 hours
 Hours Minutes

14 Industry or Business HOME

15 Social Security No.

 16 BIRTHPLACE (City) EAST BOSTON
 (State or country) MASS

17 NAME OF FATHER JOHN T. LANE

 18 BIRTHPLACE OF FATHER (City) EAST BOSTON
 (State or country) MASS

19 MAIDEN NAME OF MOTHER MARY F. MURPHY

 20 BIRTHPLACE OF MOTHER (City) EAST BOSTON
 (State or country) MASS

21 Informant MRS. MARY F. MURPHY

(Address) 39 JOHNSON 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)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

 be filed for burial permit
 with Board of Health
 or its Agent.

 INSTRUCTIONS
 FOR
 MEDICAL CERTIFICATE

 PRINT OR TYPE
 CAUSE OR CAUSES
 OF DEATH

 do not enter
 more than one
 cause for each
 of (a), (b) and (c)

 This does not mean
 he made of dying,
 such as heart failure,
 uremia, etc. It means
 he disease, or complica-
 tions 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
 in (a).

24 1965

 General Director
 Please use only
 BLACK Ink.

DOM-5-64-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



NOV 24 1965 AM

OUT - OF - TOWN

The Commonwealth of Massachusetts

235

FORM R-301

Suffolk

(County)

Boston

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 07896

No. Peter Bent Brigham Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Mrs. Alice McKinnon (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR.) Ane

(a) Permanent Residence. No. 28 Beach St. Winthrop, Mass. (City or town and State)

Length of stay: In place of death, 1 years, months, 1 days. In place of residence, 24 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 5 1965 (Month) (Day) (Year)

WE HEREBY CERTIFY, That we attended deceased from Aug 4, 1965, to Aug 5, 1965

We last saw relative on Aug 5, 1965 death is said to

have occurred on the date stated above, at 2:29 AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastrointestinal hem-

orrhage

(b) Carcinoma of Pancreas

(c) Phlebitis of lower

extremities

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

(Signature) Ting Kai Li, M. D.

(Address) PBBH Date Aug 5, 1965

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 9, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and (Signature)

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN married

11 If married, widowed, or divorced HUSBAND OF (Give maiden name of wife in full)

(or) WIFE of Angus Joseph McKinnon (Husband's name in full)

12 AGE 54 Years 6 Months 20 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. 021-03-6927

16 BIRTHPLACE (City) Italy (State or country)

17 NAME OF FATHER Vincent Marotta

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Anna Tasca

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant Angus J. McKinnon

28 Beach Rd., Winthrop

(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)

(Official Designation)

(Date of Issue of Permit)

 e filed for burial permit
 ith Board of Health
 or its Agent.

 INSTRUCTIONS
 FOR
 MEDICAL CERTIFICATE

 PRINT OR TYPE
 USE OR CAUSES
 OF DEATH

 do not enter
 more than one
 cause for each
 of (a), (b) and (c)

 This does not mean
 mode of dying,
 ch as heart failure,
 thenia, etc. It means
 e disease, or compli-
 cations which caused
 ath.

 Conditions, if any,
 which gave rise to
 above cause (a),
 stating the under-
 lying cause last.

 Conditions contrib-
 ing to death but not
 related to the terminal
 cause condition given
 (a).

MEDICAL EXAMINER DECLINED JURISDICTION

24 1965

A TRUE COPY ATTEST.

William J. Kane.
City Registrar

RECEIVED



NOV 24 1965 AM

OUT - OF - TOWN
SUFFOLKThe Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Boston

(City or Town making this return)

8019

Registered No.

FORM R-303

PLACE OF DEATH

BOSTON

(City or Town)

MEDICAL EXAMINER'S
CERTIFICATE OF DEATHNo. En route to Massachusetts General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME BEATRICE ABRAMS
(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) Permanent Residence. No 46 Bellevue Avenue, St. Winthrop, Massachusetts
(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 9, 1965
(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 Artery Disease.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? No6 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Richard Atkins, M.D.
Leonard Atkins, M.D.
25 Shattuck St., Boston
(Address) (Print or Type Name) Date 8/9 19 657 Pride of Boston Woburn
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL August 10, 19658 NAME OF FUNERAL DIRECTOR Torf Funeral Service, Inc.
ADDRESS 1615 Beacon St, BrooklineReceived and filed August 18 19 65
Richard Atkins
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) Single
12 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)
13 AGE 60 Year.....Months.....Days If under 24 hoursHours.....Minutes
14 Usual Occupation: Office Clerk
(Kind of work done during most of working life)
15 Industry or Business: Commonwealth of Massachusetts
16 Social Security No. 010-07-9475
17 BIRTHPLACE (City) Boston
(State or country) Mass.
18 NAME OF FATHER Jacob Abrams
19 BIRTHPLACE OF FATHER (City) Russia
(State or country)
20 MAIDEN NAME OF MOTHER Mary Krutchinsky
21 BIRTHPLACE OF MOTHER (City) Russia
(State or country)22 Informant Richard Abrams
(Address) 11 Verndale St. Brookline, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R Leonard 014237
(Signature of Agent of Board of Health or other)
August 10, 1965
(Official Designation) (Date of Issue of Permit)

be filed for burial permit with Board of Health or its Agent.

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

24 1965

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, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-45.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-5-6U-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



NOV 24 1965 AM

OUT - OF - TOWN

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK
(County)
ROXBURY
(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No. 08018

be filed for burial permit
with Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

No. JEWISH MEMORIAL HOSPITAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN - IMPORTANT

2 FULL NAME MAURICE RUBIN
(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) Permanent Residence. No. 25 MYRTLE AVENUE WINTHROP, MASS
(City or town and State)

PRINT OR TYPE
AUSE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
of (a), (b) and (c)

This does not mean
a mode of dying,
such as heart failure,
thrombosis, etc. It means
a disease, or complica-
tions 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
cause condition given
(c).

MEDICAL CERTIFICATE OF DEATH
3 DATE OF DEATH August 9 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
4/12/65, 1965, to 8/9/65, 1965.
I last saw him alive on 8/9/65, death is said to
have occurred on the date stated above, at 5:45 p. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) SEPTICHEMIA + TOXAEMIA
INTERVAL BETWEEN ONSET AND DEATH DAYS

Due To (b) DECUBITUS ULCERS + GANGRENE OF (L) FOOT MONTHS

Due To (c) CARCINOMA OF PROSTATE YEARS

OTHER SIGNIFICANT CONDITIONS ARTERIOSCLEROTIC HEART DISEASE. MYOCARDIAL INFARCTION YEARS

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 No

(Signature) ROBERT J. VENNY, M. D.

(Address) JEWISH MEMORIAL HOSPITAL, ROXBURY MASS Date 8/9/65

6 OHEL JACOB WOBURN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUGUST 10, 1965

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLOV

ADDRESS 1668 BEACON ST. BROOKLINE

Received and filed AUG 11 1965

William J. Kane (Registrar)

A TRUE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED

11 If married, widowed, or divorced HUSBAND of CELIA MARKELL
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 85 Years Months Days If under 24 hours Hours Minutes

13 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) RUSSIA
(State or country)

17 NAME OF FATHER SOLOMON RUBIN

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 SOLOMON RUBIN (SON)

(Address) 118 BAINBRIDGE ST. MALDEN

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Arnold Golov (Signature of Agent of Board of Health or other)

(Official Designation)

Aug 10 1965 (Date of Issue of Permit)

24 1965

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



NOV 24 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No.

BETH ISRAEL HOSPITAL

STANDARD
CERTIFICATE OF DEATH

Registered No. 08184

(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 ROGOLSKY, BENJAMIN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 29 NEPTUNE AVE St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death 0 years 0 months 23 days. In place of residence 32 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 5 15 65
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 7:23 19 65 to 8:15 19 65

I last saw him live on 8:15 19 65, death is said to have occurred on the date stated above, at 12:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PULMONARY EMBOLISM

Due To NEPHROTIC SYNDROME

(b) Due To RENAL VEIN THROMBOSIS

(c) OTHER SIGNIFICANT CONDITIONS OBSTRUCTIVE UROPATHY

CONDITIONS 2 TO CA OF PROSTATE

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

(Signature) LEE R. FOMMER, M. D.

(Address) 368 LONG WOOD Date 8:15 19 65

6 Mt. Lebanon JEWISH BENEVOLENT West Rox.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 16, 1965

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St. Brookline

Received and filed AUG 17 1965

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR White 10 SINGLE (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of Sarah Reingold

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 77 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Real Estate Mngr.

(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 Louis Rogolsky

18 BIRTHPLACE OF FATHER (City) Russia

(State or country)

19 MAIDEN NAME OF MOTHER Shayne Unknown

20 BIRTHPLACE OF MOTHER (City) Russia

(State or country)

21 Informant Saul Rogolsky

(Address) 3 Brighton St. Watertown

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

7. P. Maca 014425

(Signature of Agent of Board of Health or other) (Date of Issue of Permit) August 16 1965

RM R-301

for burial permit

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CTIONS

OR

CERTIFICATE

OR TYPE

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DEATH

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24 1965

-93648

A TRUE COPY ATTEST:

U.S.K.

A TRUE COPY ATTEST:

William J. Kane.
CLERK



NOV 24 1965 AM

PLACE OF DEATH

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

239
(City or Town making this return)

Registered No. 08407

GEN ROUTE TO MASSACHUSETTS GENERAL HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JOHN FOX No
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 165 BOWDOIN 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. 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST 20 1965
(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.)

SKULL FRACTURES, LACERATION OF BRAIN,
SUBDURAL HEMATOMA

5 Accident, suicide, or homicide (specify) ACCIDENT

Date and hour of injury JUNE 10 19 65

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? ABOUT HOME
(Specify type of place)

Manner of injury FALL FROM LADDER
(How did injury occur?)

Nature of injury HEAD TRAUMA

While at work? Was autopsy performed? YES

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.

(Address) 25 SHATTUCK ST. Date AUG. 21 19 65

7 Winthrop Winthrop Mass
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Aug. 23 19 65

8 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St, Winthrop

Received and filed AUG 25 1965

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Single

12 If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)
(or) WIFE of _____
(Husband's name in full)

13 AGE 71 years 3 months 19 days
If under 24 hours _____ Hours _____ Minutes

14 Usual Occupation: Carpenter
(Kind of work done during most of working life)

15 Industry or Business: Boat Builder

16 Social Security No. _____

17 BIRTHPLACE (City) Chester
(State or Country) Penn.

18 NAME OF FATHER George Fox

19 BIRTHPLACE OF FATHER (City) Dewsbury
(State or country) England

20 MAIDEN NAME OF MOTHER Louisa Downes

21 BIRTHPLACE OF MOTHER (City) Upland
(State or country) Penn.

22 Informant (Address) Mrs Helen Gillis
12 Park Ave, Winthrop Mas

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

C14661 Kenneth W. Ford
(Signature of Agent of Board of Health or other)

(Official Designation) Aug. 24, 1965 (Date of Issue of Permit)

4 1965

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



NOV 24 1965 AM

FORM R-301

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts

 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

240

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

08448

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Teresa Rossetti

(If deceased is a married, widowed or divorced woman, give also maiden name.)

211 Cliff Avenue

Winthrop

(Was deceased a U. S. War Veteran, so specify WAR)

no

(a) Permanent Residence. No. Ocean View Manor Nursing Home St. Rensselaire, Massachusetts

(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 August 23, 1965

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 20, 1965 to August 23, 1965

I last saw him alive on August 23, 1965 death is said to

have occurred on the date stated above, at 4:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lobar pneumonia

several

(b) Due To Coronary atherosclerosis

48 hours

(c) Due To

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

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Ass'n. Dir., Mass. Gen'l. Hosp. Date August 23, 1965

6 St. Michael Cemetery Boston

Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 26, 1965

7 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed AUG 27 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Nicholas Rossetti

(Husband's name in full)

12 AGE 78 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. none

16 BIRTHPLACE (City) Italy

(State or country)

17 NAME OF FATHER Louis Rodophele

18 BIRTHPLACE OF FATHER (City)

(State or country)

Italy

19 MAIDEN NAME OF MOTHER Sarah (unknown)

20 BIRTHPLACE OF MOTHER (City)

(State or country)

Italy

21 Informant Mary Lunetta (daughter)

(Address) 211 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:

J. P. Rapino C 147000

(Signature of Agent of Board of Health or other)

(Official Designation)

Aug 27, 1965

(Date of Issue of Permit)

A TRUE COPY ATTEST:

 filed for burial permit
 with Board of Health
 or its Agent.

 INSTRUCTIONS
 FOR
 MEDICAL CERTIFICATE

 PRINT OR TYPE
 USE OR CAUSES
 OF DEATH

 do not enter
 more than one
 cause for each
 (a), (b) and (c)

 This does not mean
 a mode of dying,
 such as heart failure,
 pneumonia, etc. It means
 a 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).

12 4 1965

 Funeral Director
 please use only
 BLACK Ink.

1 M-5-64-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



NOV 24 1865 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

241

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 08587

No. 818 Harrison Ave.

St. {If death occurred in a hospital or institution,
give its NAME instead of street and number}

2 FULL NAME G. E. FRONDELLO

(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)

153 Locust

(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.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 28 1965
(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.)

Chronic pulmonary tuberculosis -
malnutrition -

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?

(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) Richard J. Ford, M. D.

(Print or Type Signature)

(Address) 8-28 1965

7 Winthrop Cemetery Winthrop
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL August 31, 1965

8 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed SEP 1 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)
male white MARRIED
WIDOWED
or DIVORCED widowed

11a If married, widowed, or divorced
HUSBAND of Anna M. Battaglia
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 73 Years.....Months.....Days If under 24 hours
Hours.....Minutes

14 Usual Occupation: Retired
(Kind of work done during most of working life)

15 Industry or Business: *****

16 Social Security No 011-16-0751

17 BIRTHPLACE (City) Italy
(State or country)

18 NAME OF FATHER Giuseppe Frongello

19 BIRTHPLACE OF FATHER (City) Italy
(State or country)

20 MAIDEN NAME OF MOTHER Pasqualina DeFave

21 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

22 Informant Antonette Frongello (daughter)
(Address) 153 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
August 30 1965

(Official Designation)

(Date of Issue of Permit)

PLEASE COPY ATTEST:

William L. Kane.
Civ Registrar

RECEIVED



DEC - 1 1965 AM

FORM R-301

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 09247

CHILDREN'S HOSPITAL MEDICAL CENTER, St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME FARO, JAMES Leonard
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a U. S. War Veteran, if so specify WARI) No

(a) Permanent Residence. No. 169 COURT ROAD St. WINTHROP, MASSACHUSETTS
(City or town and State)

Length of stay: In place of death, 17 years, 0 months, 17 days. In place of residence, 2 years, 0 months, 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 15, 1965

(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from AUGUST 30 19 65 to SEPTEMBER 15 19 65

I last saw him live on SEPTEMBER 15 19 65 death is said to

have occurred on the date stated above, at 9:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardio Vascular Failure

(b) Due To Acute Leukemia

(c) Due To

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

(Signature) Owen C. Grush, M. D.

OWEN C. GRUSH

(Address) 300 LONGWOOD AVE Date 9-15-19 65

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 18 1965

7 NAME OF FUNERAL DIRECTOR JOE RUSSO

ADDRESS 814 AMERICAN LEGION PARKWAY

Received and filed SEP 20 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 9 Years 6 Months Days If under 24 hours Hours Minutes

13 Usual Occupation at school (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 Angelo Faro

18 BIRTHPLACE OF FATHER (City) Boston Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Ann Maiolino

20 BIRTHPLACE OF MOTHER (City) Boston Mass.
(State or country)21 Informant Angelo Faro - father
169 Court Rd. Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

C15470 / [Signature] (Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



DEC 16 1965 AM

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

09411

2 FULL NAME Joseph Dalton

(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) no

(a) Permanent Residence. No. 76 Atlantic St.

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months 2 days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 20, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1965, to September 20, 1965, and last saw him live on September 20, 1965, death is said to

have occurred on the date stated above, at 4:35 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PULMONARY EDEMA ACUTE

INTERVAL
BETWEEN
ONSET AND
DEATH
HOURS

Due To CONGESTIVE HEART FAILURE

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS OBESITY

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

(Signature) M. D.

Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Sept 20, 1965

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL

September 24, 1965

7 NAME OF FUNERAL DIRECTOR O'Maley Funeral Home

ADDRESS Winthrop, Mass.

Received and filed SEP 27 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

 8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married
 WIDOWED DIVORCED UNKNOWN

11 If married, widowed or divorced HUSBAND of Gertrude Lundberg

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 55 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 Milk Salesman

15 Social Security No. 025-05-2540

16 BIRTHPLACE (City) East Boston Mass
(State or country)

17 NAME OF FATHER Joseph J. Dalton

18 BIRTHPLACE OF FATHER (City) Chelsea Mass
(State or country)

19 MAIDEN NAME OF MOTHER Annie Emmett

20 BIRTHPLACE OF MOTHER (City) East Boston Mass
(State or country)21 Informant Gertrude Dalton
76 Atlantic St., Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Dignus Leonard c 15890
(Signature of Agent of Board of Health or other)

(Official Designation)

Sept 23 1965
(Date of Issue of Permit)
 ed for burial permit
 Board of Health
 or its Agent.

 INSTRUCTIONS
 FOR
 CERTIFICATE

 NT OR TYPE
 E OR CAUSES
 OF DEATH

 to not enter
 pre than one
 use for each
 a), (b) and (c)

 s 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),
 including the under-
 lying cause last.

 conditions contrib-
 ute to death but not
 lead to the terminal
 condition given

34.1

42

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1, 1965

ral Director

see use only

LACK INK.

5-64-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



DEC - 1 1965 AM

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

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 Margaret Mary Sennett (King) { (Was deceased a
(If deceased is a married, widowed or divorced woman, give also maiden name.) U. S. War Veteran,
if so specify WAR) No

(a) Permanent Residence. No. 15 Palmyra St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months6.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 9 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Oct 3 1965, to Oct 9 1965.
I last saw her alive on October 8 1965 death is said to
have occurred on the date stated above, at 7:45a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Peritonitis

Due To Cholecystitis

(c) Cholelithiasis

OTHER SIGNIFICANT CONDITIONS Old Myocardial Infarction
Choleductocolostomy

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

(Signature) Willard M. Hausman, M. D.
Willard M. Hausman

(Address) Hathorne, Mass Date 10-9 1965

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 11 1965

7 NAME OF FUNERAL DIRECTOR Kirby Funeral Home

ADDRESS Winthrop, Mass

Received and filed NOV 18 1965 10-15 1965

(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
DIVORCED
UNKNOWN widowed

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Unknown Sennett
(Husband's name in full)

12 AGE 75 Years 6 Months 8 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) Boston
(State or country) Mass

17 NAME OF FATHER -----King

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER -----Connolly

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST Tracy I. Flagg Ronell J. Toomey
(Registrar of City or Town where death occurred)

Dir of Public Health 10-9-65 1965

DATE FILED

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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

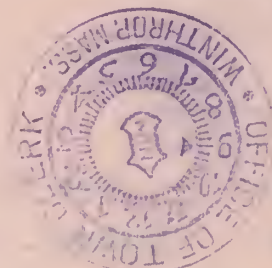
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

NOV 18 1965 AM



RECEIVED

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers
(City of Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)

No. Danvers State Hospital-Nathorne St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Forrest Huey
(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) Permanent Residence. No. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 3 years 7 months 15 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 23 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 8 1962 to October 23 1965
I last saw him live on October 23 1965, death is said to have occurred on the date stated above, 4:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion Hours

Due To (b) Arteriosclerotic hnt dis Years

Due To (c) Gen. Arteriosclerosis Years

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Lab

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Willard M. Hausman, M. D.
Willard M. Hausman

(Address) Nathorne, Mass. Date 10-23 1965

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 30 1965

7 NAME OF FUNERAL DIRECTOR Reynolds Funeral Home

ADDRESS Winthrop, Mass.

Received and filed NOV 18 1965 11-1-65

(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
DIVORCED
UNKNOWN single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 42 Years 4 Months 12 Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation Retired Steamboat Pilot
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. Unknown

16 BIRTHPLACE (City) N.S., Canada
(State or country)

17 NAME OF FATHER Austin Huey

18 BIRTHPLACE OF FATHER (City) N.S., Canada
(State or country)

19 MAIDEN NAME OF MOTHER Annie F. Horn

20 BIRTHPLACE OF MOTHER (City) N.S., Canada
(State or country)

21 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY

ATTEST: Tracy L. Flagg
(Registrar of City or Town where death occurred)

Dir of Public Health 10-27-65
DATE FILED 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-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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

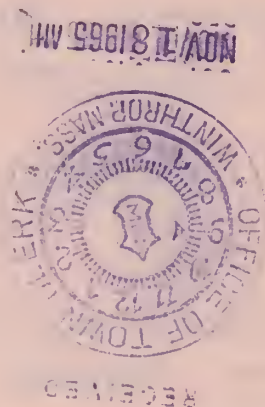
DATE OF DISCHARGE

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-10-61-931673

PLACE OF DEATH

(County) **BROOKLINE**
(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

246

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 755

No. **Free Hospital for Women, 245 Pond Avenue** (If death occurred in a hospital or institution, give its NAME instead of street and number)
(also known as Antonette Alioto)

2 FULL NAME **Nora Alioto (Langone)**
(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. **203 River Road,** **xx Winthrop, Massachusetts**
(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 **2** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **October 24 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **Oct 10**, 19 **65**, to **October 24**, 19 **65**.
I last saw h.....alive on **October 24**, 19 **65**, death is said to have occurred on the date stated above, at **3:35 P.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Septicemia**
Due To **Peritonitis**
(b) **11 days**

(c) **Metastatic Ovarian Carcinoma**

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) **Ann B. Barnes** M. D.
245 Pond Avenue
Brookline, Mass **Oct 24 1965**
(Address) (Date)

Holy Cross **Malden, Mass.**
6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL **October 27** 19 **65**

7 NAME OF FUNERAL DIRECTOR **Ernest P. Caggiano**

ADDRESS **147 Winthrop St., Winthrop, Mass.**
NOV 22 1965

Received and filed19.....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word) **Widowed**
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of **Anthony Alioto**
(Husband's name in full)

12 **66** **1** **24**
AGE.....Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation **Stitcher**
(Kind of work done during most working life)

14 Industry **Garment**
or Business:

15 Social Security No. **023-24-3560**

16 BIRTHPLACE (City) **Boston**
(State or country) **Massachusetts**

17 NAME OF FATHER **Rosario Langone**

18 BIRTHPLACE OF FATHER (City) **Italy**
(State or country)

19 MAIDEN NAME OF MOTHER **Aurelia Mannarino**

20 BIRTHPLACE OF MOTHER (City) **Italy**
(State or country)

21 Informant **Victor Alioto**
(Address) **203 River Road, Winthrop, Massachusetts**

A TRUE COPY
ATTEST: **Arthur J. Shinnors**
(Registrar of City or Town where death occurred)

DATE FILED **October 27** 19 **65**

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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

247

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

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 CARMEN PAOLILLO
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, *None*
if so specify WAR)(a) Permanent Residence. No. 27 HAURE
(Usual place of abode)St. East Boston
(City or town and State)

Length of stay: In place of death. years. months. 1 hr. In place of residence. 30 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 1, 1965.
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Feb 15, 1965, to Nov 1, 1965.
I last saw him alive on Nov 1, 1965, death is said to
have occurred on the date stated above, at 10:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Broncho pneumonia

(b) Due To Pulm. Fibrosis &

(c) Due To Emphysema

INTERVAL
BETWEEN
ONSET AND
DEATH

7 days

1966

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 100

(Signature) W. H. P. P. M. D.

(Address) 17A Benn St E B Date 11-2 1965

Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 5 1965

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS East Boston

Received and filed NOV 2 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Jacqueline Rallo
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 78 Years. Months. Days If under 24 hours
Hours. Minutes13 Usual Occupation Variety Store Operator
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. CNBL

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Andrew Paolillo

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Micheline Scoffi

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Jacqueline Paolillo
(Address) 27 HAURE St. E. BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Goffney
(Signature of Agent of Board of Health or other)
Director of Public Health Nov 4 1965
(Official Designation) (Date of Issue of Permit)

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 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.

burial permit
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(County)Winthrop
(City or Town)

No. Bayview Nursing Home

2 FULL NAME James H. Richardson
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 38 Harvard Street
(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) NoSt. Everett, Mass.
(City or town and State)

Length of stay: In place of death years 2 months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 5, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
OCT. 1, 1965, to NOV. 5, 1965.
I last saw him alive on NOV. 5, 1965, death is said to
have occurred on the date stated above, at 3:05 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of prostate with
widespread metastasisINTERVAL
BETWEEN
ONSET AND
DEATH

3 YRS.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Bilateral hydronephrosis

2 Mos.

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(Signature) Maurice Traubstein, M. D.
MAURICE TRAUBSTEIN, Jr. (M.D.)

(Print or Type Name)

(Address) 73 Bartlett Rd., WINTHROP, MASS.
Date NOV 5, 19656 Glenwood Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 8, 1965

7 NAME OF FUNERAL DIRECTOR J.E. Henderson Co.

ADDRESS 517 Broadway, Everett, Mass.

Received and filed NOV 8 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

248

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered 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) NoSt. Everett, Mass.
(City or town and State)

Length of stay: In place of death years 2 months days. In place of residence 30 years months days.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR Colored 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed11 If married, widowed, or divorced
HUSBAND of Pearl E. Noiles
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 74 Years 3 Months 0 Days If under 24 hours
Hours Minutes13 Usual Occupation Clerk
(Kind of work done during most of working life)

14 Industry or Business S.S. Pierce Co.

15 Social Security No. 021-05-5026

16 BIRTHPLACE (City) Chelsea, Mass.
(State or country)

17 NAME OF FATHER James W. Richardson, 2nd

18 BIRTHPLACE OF FATHER (City) Virginia
(State or country)19 MAIDEN NAME OF MOTHER ANNIE
C.N.B.L. GREGORY20 BIRTHPLACE OF MOTHER (City) Virginia
(State or country)21 Informant James W. Richardson, 2nd
(Address) 15 Bennett Street, EverettI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Goffney, Jr.
(Signature of Agent of Board of Health or other)Director of Public Health Nov 8 '65
(Official Designation) (Date of Issue of Permit)

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.

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 249

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home, Sturgis

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eudora Maxwell O'Connor

(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 Peterboro St.

(Usual place of abode)

St. Boston, Mass

(City or town and State)

Length of stay: In place of death, 3 years, 21 months, 21 days. In place of residence, 30 years, 6 months, 6 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER Six, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1962, to Nov. 6, 1965

I last saw her alive on Nov. 5, 1965, death is said to have occurred on the date stated above, at 12:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) HEART FAILURE (arteriosclerosis)

INTERVAL BETWEEN ONSET AND DEATH

12 hrs

(b) Due To GENERAL CARDIO-RENAL SCLEROSIS

6 mos.

(c) Due To HYPOTENSIVE PNEUMONIA

1 day

OTHER SIGNIFICANT CONDITIONS

Considerable fluid bases of lung

Was autopsy performed? No

What test confirmed diagnosis? STETHOSCOPIC EXAMINATION

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Wallace Haley, M.D.

WALLACE HALEY, M.D.

(Print or Type Name)

(Address) 35 Peterboro St., Boston, Date Nov. 6, 1965

6 Forest Hills Cem. Boston

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL NOV 8, 1965

7 NAME OF FUNERAL DIRECTOR J. S. Waterman - Sensitive

ADDRESS 495 Commonwealth Ave Boston

Received and filed NOV 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

FEMALE

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN
SINGLE

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12

AGE 83 Years, 0 Months, 3 Days

If under 24 hours

Hours, Minutes

13 Usual Occupation

HOUSE KEEPER AT HOME (Kind of work done during most of working life)

14 Industry or Business

BROOKER IN STATE ST. BAKERY ST FOR 38 yrs

15 Social Security No. 020-12-2447-A

16 BIRTHPLACE (City, State or country) TOWN OF PHEBUS, VIRGINIA, U.S.A.

17 NAME OF FATHER

JAMES FRANCIS O'CONNOR

18 BIRTHPLACE OF FATHER (City, State or country)

TOWN OF WEXFORD, IRELAND

19 MAIDEN NAME OF MOTHER

Eudora Adelaide Maxwell

20 BIRTHPLACE OF MOTHER (City, State or country)

of BRUNSWICK, MAINE, U.S.A.

21 Informant

(Sister) Mrs. Amanda A. Carroll

(Address) 96 Bay State Road, Boston, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney

(Signature of Agent of Board of Health or other)

Director of Public Health Nov 8, 1965

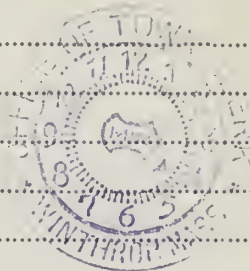
(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

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NOV - 9 1965 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.

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Suffolk

(County)

Winthrop

(City or Town)

No. 38 Enfield Road

John Arthur Wilson

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

38 Enfield Road

(a) Residence. No. (Usual place of abode)

Length of stay: In place of death 35 years months days. In place of residence 65 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 6 1965 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1960 to Nov. 6 1965. I last saw him alive on Nov. 5 1965 death is said to have occurred on the date stated above, at 7:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Arteriosclerosis 2 yrs

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Osteoarthritis

INTERVAL BETWEEN ONSET AND DEATH

5 yrs

Was autopsy performed?

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

(Signature) Charles Liberman M. D.

(Address) WINTHROP, MASS Date 11/8/65

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 9 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

Winthrop, Mass

ADDRESS

Received and filed NOV 8 1965

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
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) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Maude E. Shorey (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 86 Years 7 Months 23 Days If under 24 hours Hours Minutes

13 Usual Occupation: Superintendent (Retired) (Kind of work done during most of working life)

14 Industry or Business: Building

15 Social Security No. 012-17-7839

16 BIRTHPLACE (City) East Boston (State or country) Mass.

17 NAME OF FATHER Charles Wilson

18 BIRTHPLACE OF FATHER (City) Norway (State or country)

19 MAIDEN NAME OF MOTHER Emma C Anderson

20 BIRTHPLACE OF MOTHER (City) Sweden (State or country)

21 Informant A. Madeline Birkmaier

(Address) 49 Waldemar 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:

Paul C. Coffey (Signature of Agent of Board of Health or other) Director of Public Health Nov 8 '65 (Official Designation) (Date of Issue of Permit) K.A.V.

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

NOV - 8 1965 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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **251**

PLACE OF DEATH

Suffolk (County)

Winthrop (City or Town)

No. Bay View Nursing Home

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Catherine Chandler
(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) Permanent Residence. No. 92 Oak Street,

St. Natick,

MASS
(City or town and State)

Length of stay: In place of death 6 years 9 months 9 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 9, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1959 to Nov. 9, 1965

I last saw him alive on October 24, 1965, death is said to have occurred on the date stated above, at 10:45 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Dis.

INTERVAL BETWEEN ONSET AND DEATH

5 Years

(b) Arteriosclerosis

10 Yrs.

(c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical findings

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) John F. Collins M.D.

John F. Collins M.D.
(Print or Type Name)

(Address) Revere, Mass. Date Nov. 11, 1965

6 Old Calvary Cemetery Boston, MASS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOVEMBER 12, 1965

7 NAME OF FUNERAL DIRECTOR A. F. McHoul

ADDRESS 35 V. DAMS ST - DORCHESTER MASS

Received and filed NOV 12 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED WIDOW UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

JAMES F. CHANDLER
(Husband's name in full)

12 AGE 82 Years Months Days

If under 24 hours Hours Minutes

13 Usual Occupation PASTRY COOK RETIRED
(Kind of work done during most of working life)

14 Industry or Business: UNION OYSTER HOUSE

15 Social Security No. 011-20-1983

16 BIRTHPLACE (City) CO. F. ASSET MASS
(State or country)

17 NAME OF FATHER MICHAEL LAVENDIER

18 BIRTHPLACE OF FATHER (City) ANTIGONISH N. S.
(State or country)

19 MAIDEN NAME OF MOTHER GENEVIEVE LANDRY

20 BIRTHPLACE OF MOTHER (City) ANTIGONISH N. S.
(State or country)

21 Informant JAMES CHANDLER (son)

(Address) 92 OAK ST. NATICK, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Coffey (S)

(Signature of Agent of Board of Health or other)

Director of Public Health NOV 12, 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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.

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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.



1 R-301

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PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Mr. Allen E. Newton

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 258 Court Rd. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years 1 months 22 days. In place of residence. 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 11 13 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Sept. 22, 1965, to Nov. 13, 1965I last saw him alive on Nov. 13, 1965, death is said to
have occurred on the date stated above, at 11.05A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cirrhosis of Liver

INTERVAL
BETWEEN
ONSET AND
DEATH

6 Weeks

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Cholecystitis Cholelithiasis 6Wks

Was autopsy performed? Yes

What test confirmed diagnosis Pathological Specimen

5 Was disease or injury in any way related to occupation of deceased No

If so, specify

(Signature) John F. Collins M.D.

John F. Collins M.D.

(Print or Type Name)

(Address) Revere, Mass. Date Nov. 14 1965

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 16, 1965

7 NAME OF
FUNERAL DIRECTOR

Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed NOV 16 1965

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No.

252

{(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

male white

11 If married, widowed, or divorced

HUSBAND of Edith Sawyer Newton

(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12

AGE 80 Years 5 Months 27 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation merchant

(Kind of work done during most of working life)

14 Industry

or Business: Wholesale Fish Business

15 Social Security No. 029-03-6257

16 BIRTHPLACE (City) East Boston

(State or country) Massachusetts

17 NAME OF

FATHER Edward Bartlett Newton

18 BIRTHPLACE OF

FATHER (City) Weymouth

(State or country) Massachusetts

19 MAIDEN NAME

OF MOTHER Emily Brewster

20 BIRTHPLACE OF

MOTHER (City) Tamworth

(State or country) New Hampshire

21 Informant Eleanor S. Newton

(Address) 258 Court Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Giffney Jr.

(Signature of Agent of Board of Health or other)

Director of Public Health

(Official Designation)

(Date of Issue of Permit) Nov. 15, 1965

763

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:

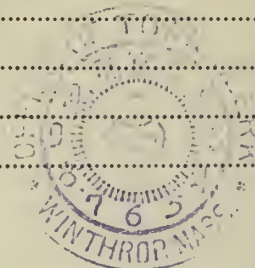
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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given 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.



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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

253

Registered No.

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 A. Murphy
(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) Permanent Residence. No. 145 Main Street

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....1 days. In place of residence 40 years.....months.....days.

✓ MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 11 15 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
SEPT. 7, 1953, to NOV 11, 1965

I last saw her alive on NOV 11, 1965, death is said to
have occurred on the date stated above, at 2:35 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ADENOCARCINOMA OF LEFT
BREAST(b) GENERAL CARCINOMATOSIS(c) PLEURAL EFFUSION

INTERVAL
BETWEEN
ONSET AND
DEATH

3 1/2 YRS.

1 YR.

6 mo.

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NoWhat test confirmed diagnosis? Pathological

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Myron H. King, M. D.

(Print or Type Name) Winthrop, Mass. Date Nov. 15 65
(Address) (City or Town)

6 Holy Cross Malden, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 17, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed NOV 16 1965

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Single

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 56 Years.....Months.....Days If under 24 hours
..... Hours..... Minutes

13 Usual Occupation Telephone Operator
(Kind of work done during most of working life)

14 Industry or Business: N.E. Tel. & Tel

15 Social Security No. 011-05-1505

16 BIRTHPLACE (City). East Boston
(State or country) Mass

17 NAME OF FATHER Joseph A. Murphy

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Julia Callahan

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Josephine M. Mercier

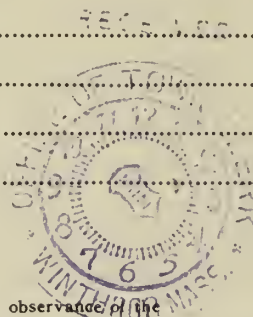
(Address) 85 Beal St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul O. Rafferty
(Signature of Agent of Board of Health or other)

Director of Public Health Nov 16, 1965
(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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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)

Registered No. **251**2 FULL NAME **WALTER** **DiPESA**
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. **29 Winthrop Parkway,** St. **Revere, Mass.**
(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 **November 15, 1965**
(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.)
Barbiturate poisoning.5 Accident, suicide, or homicide (specify) **Unknown.**
Date and hour of injury **November 12, 1965**

IF ACCIDENTAL, was injury causally related to the death? _____

Where did injury occur? **Revere, 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 **Ingestion of overdose of barbiturate.**
(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 **11/16 1965**
(Print or type Name)7 **Holy Cross Malden**
Place of Burial or Cremation. (City or Town)DATE OF BURIAL **NOV. 19 1965**8 NAME OF FUNERAL DIRECTOR **Paul Buonfiglio**
ADDRESS **128 REVERE ST. REVERE**Received and filed **November 17, 1965**

A TRUE COPY ATTEST:

(Registrar)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSMEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(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

9 SEX **MALE** 10 COLOR **WHITE** 11 SINGLE **SINGLE** (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN12 If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)13 AGE **58** Years **11** Months _____ Days _____ If under 24 hours
Hours _____ Minutes _____14 Usual Occupation: **PROPRIETOR**
(Kind of work done during most of working life)15 Industry of Business: **RESTAURANT**16 Social Security No. _____
17 BIRTHPLACE (City) **REVERE, MASS.**
(State or country)18 NAME OF FATHER **FRANK DiPESA**19 BIRTHPLACE OF FATHER (City) **Italy**
(State or country)20 MAIDEN NAME OF MOTHER **Amalia Statuti**21 BIRTHPLACE OF MOTHER (City) **Italy**
(State or country)22 Informant (Address) **FRANK DiPESA**
29 WINTHROP Pkwy, REVERE

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (M.D.)
(Signature of Agent of Board of Health or other)
Director of Public Health **11/17/65**
(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

NOV 17 1965 AM

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

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.)"

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. 255

2 NAME OF FETUS
(if given)

Baby Boy Christian

3 DATE OF
DELIVERY

Nov. 18. 1965

(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

Christian, Richard F.

9 RESIDENCE, NO. 5 Meryl St.

STREET

CITY OR TOWN Medway

STATE Mass.

10 COLOR OR
RACE W11 AGE AT TIME OF
THIS DELIVERY 33 (Years)12 PLACE OF
BIRTH Boston, Mass.
(City or Town) (State or country)

MOTHER

14 MAIDEN NAME

Finch, Barbara

PRESENT NAME

Christian, Barbara

15 RESIDENCE, NO. 5 Meryl St.

STREET

CITY OR TOWN Medway

STATE Mass.

16 COLOR OR
RACE W17 AGE AT TIME OF
THIS DELIVERY 31 (Years)18 PLACE OF
BIRTH Milton, Mass.
(City or Town) (State or country)

19 INFORMANT Richard F. Christian

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

3

(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
completed weeks 4022 Weight Lb. 6 Oz. 12
OF FETUS
(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) still born

Due To (b) Premature separation of Placenta

Due To (c)

OTHER SIGNIFICANT
CONDITIONS

26 Holy Cross Cemetery Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Nov. 23

1965

27 NAME OF
FUNERAL DIRECTOR

Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed

NOV 22 1965

19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 0:50 P.M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

A. Paul DE RHAGOPIAN

M.D.

A. Paul DE RHAGOPIAN, M.D.
(PRINT OR TYPE NAME)

Address 34 CARY AVE, CHELSEA Date Nov. 19 1965

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (B)

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 11/22/65

RECEIVED



FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

NOV 23 1965 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.

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burial permit
of Health
Agent.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 256

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 HERMAN DINEFRIED
(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. 176 Shore Drive
(Usual place of abode)

(City or town and State)

Length of stay: In place of death, 3 years.....months.....days. In place of residence 21 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 18 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 1955 to 11/18/1965
I last saw him alive on 11/17/1965, death is said to
have occurred on the date stated above, at 4:35 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease 24 yrs.
(b) Generalized Arteriosclerosis 5 yrs.
(c)INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
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(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 11/18/1965

6 PRIDE OF BOSTON Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 19 1965

7 NAME OF FUNERAL DIRECTOR ROBERT LeVINE

ADDRESS 1668 Beacon St. Brookline

Received and filed NOV 19 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced HUSBAND of Reva Rachesky
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 74 Years 6 Months 9 Days If under 24 hours
Hours.....Minutes13 Usual Occupation (Retail Liquors) Salesman
(Kind of work done during most of working life)

14 Industry or Business RETIRED

15 Social Security No. 029-22-2627

16 BIRTHPLACE (City) GERMANY
(State or country)

17 NAME OF FATHER Adolph Dinefriend

18 BIRTHPLACE OF FATHER (City) GERMANY
(State or country)

19 MAIDEN NAME OF MOTHER Rosa Heyman

20 BIRTHPLACE OF MOTHER (City) GERMANY
(State or country)

21 Informant Rosalind Letterman

(Address) 176 Shore Drive

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Gaffney (P)
(Signature of Agent of Board of Health or other)
Director of Public Health Nov 19 '65
(Official Designation) (Date of Issue of Permit)

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.

RECEIVED



NOV 19 1965 PM

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burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 257

{(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) no1 PLACE OF DEATH
Suffolk
Winthrop
(City or Town)
No 380 Pleasant
2 FULL NAME George Lambie
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No 380 Pleasant St.
(Usual place of abode) (City or town and State)

Length of stay: In place of death years 11 months days. In place of residence years 11 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 19 1965
(Month) (Day) (Year)
4 I HEREBY CERTIFY That I attended deceased, from July 19 65 to Nov 19 65
I last saw him alive on Nov 19 19 65, death is said to have occurred on the date stated above, at 12 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral thrombosis

(b) arteriosclerosis

(c) Due To

OTHER SIGNIFICANT CONDITIONS
hypertrophy of prostate
cystitis

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

(Signature) H. B. Coontz, M. D.

(Address) 447 Cherry St. Winthrop Date 11-22-65

Buritan Lawn Mem PH. Peabody
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 22 19 65

7 NAME OF FUNERAL DIRECTOR Daniel H. Clancy

Address 600 Washington St Weymouth

Received and filed 19

NOV 22 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED
11 If married, widowed, or divorced HUSBAND of Beatrice A. Pourke (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 83 Years 7 Months 2 Days If under 24 hours Hours Minutes

13 Usual Occupation Plumber (Kind of work done during most of working life)

14 Industry or Business Self Employed

15 Social Security No 030-01-15067A

16 BIRTHPLACE (City) Scotland (State or country)

17 NAME OF FATHER John Lambie

18 BIRTHPLACE OF FATHER (City) Scotland (State or country)

19 MAIDEN NAME OF MOTHER Catherine Sellars

20 BIRTHPLACE OF MOTHER (City) Scotland (State or country)

21 Informant Catherine M. Donoghue

(Address) 380 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:

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.

NOV 22 1965 PM



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. 258

PLACE OF DEATH

Suffolk

(County)

WINTHROP

(City or Town)

No. 148 Shore Drive

2 FULL NAME Sidney Borkow
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 148 Shore Drive St. Winthrop
(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 years 4 months days.

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

NO

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 20 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw h. alive on 19, death is said to
have occurred on the date stated above, at 6:45 P. M.DISEASE OR CONDITION
DIRECTLY LEADING
TO DEATH (a) ACUTE CORONARY
OCCLUSION 10 hrsDISEASE OR CONDITION
DUE TO MYOCARDIAL DISEASE 3 YRS.DUE TO ARTERIO-SCLEROTIC
HEART DIS 3 YRSINTERVAL BE-
TWEEN ONSET
AND DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR OR RACE white 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED WIDOWED
or DIVORCED or DIVORCED10a If married, widowed, divorced
HUSBAND of FRANCES BORENSTEIN
(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 Minutes13 Usual Occupation: Electronics Worker.
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 011-03-7099.

16 BIRTHPLACE (City)
(State or country) Russia

17 NAME OF FATHER (UNKNOWN)

18 BIRTHPLACE OF FATHER (City)
(State or country) Russia

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City)
(State or country) Russia21 Informant Edward Borkow
(Address) Winthrop MassI HEREBY CERTIFY that a satisfactory standard certificate of death was
filed with me BEFORE the burial or transit permit was issued:Paul C Gaffney (s)
(Signature of Agent of Board of Health or other)Director of Public Health 11/20/65
(Official Designation) (Date of Issue of Permit)OTHER
SIGNIFICANT
CONDITIONSMajor findings:
Of operations:

Date of operation: 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)

(Address)

Date 11/20 1965

6 USUAL RESIDENCE West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 20th 1965

7 NAME OF FUNERAL DIRECTOR Arnold Galow

ADDRESS 1668 Beacon St Bklyn.

Received and filed NOV 22 1965 19

(Registrar)

PARENTS

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 exhum 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 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, 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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burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 259

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 Margaret Gertrude Cochrane
(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) Permanent Residence. No. 102 Pleasant St.
(Usual place of abode) St. (City or town and State)

Length of stay: In place of death. years 2 months 2 days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 20 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN 9 1954 to Nov 20 1965
I last saw him alive on Nov 20 1965, death is said to
have occurred on the date stated above, at 7:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR HEMORRHAGE
(b) HYPERTENSION & MYOCARDIAL INFARCTION
(c) TENSIVE HEART DISINTERVAL
BETWEEN
ONSET AND
DEATH

26 Hrs

6 YRS

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(Signature) Myron N. King, M. D.
(Print or Type Name)
(Address) 121 Pleasant St. Winthrop, Mass. Date 11/22/656 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 23, 1965

7 NAME OF
FUNERAL DIRECTOR

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed NOV 22 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Single
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 67 Years 4 Months 1 Days If under 24 hours
Hours Minutes13 Usual Occupation ret. Assistant Credit Mgr.
(Kind of work done during most of working life)

14 Industry or Business Record American Newspaper

15 Social Security No. 012-07-9915

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

17 NAME OF FATHER John Cochrane

18 BIRTHPLACE OF FATHER (City) St. John
(State or country) New Brunswick

19 MAIDEN NAME OF MOTHER Margaret Minahan

20 BIRTHPLACE OF MOTHER (City) Chatham
(State or country) England21 Informant John Stephen Mullen
(Address) 42 Feeding Hills, 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
Director of Public Health) 11/22/65
(Official Designation) (Date of Issue of Permit)

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.

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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.

NOV 22 1965 PM



burial permit
of Health
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 260

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 41 Thornton Park

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Cynthia Hill Butt (Johnson)
(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) Permanent Residence. No. 41 Thornton Park st. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 5.5 years months days. In place of residence 5.5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 21 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Aug., 1964, to Nov. 21, 1965
I last saw him alive on Nov. 16, 1965, death is said to
have occurred on the date stated above, at 8.45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial Heart Disease

(b) arteriosclerosis-gen.

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER
SIGNIFICANT
CONDITIONS

Senility

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Joseph B. Grogan, M. D.

(Print or Type Name) JOSEPH B. GROGAN

(Address) 194 Washington St. Date 11-22-1965

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 24, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed NOV 22 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of

(or) WIFE of Herbert George Butt
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 93 Years 7 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) Topshfield
(State or country) Maine

17 NAME OF FATHER Robinson Lincoln Johnson

18 BIRTHPLACE OF FATHER (City) Maine
(State or country)

19 MAIDEN NAME OF MOTHER Laura Hall

20 BIRTHPLACE OF MOTHER (City) Maine
(State or country)

21 Informant Miss. L. Mildred Butt
(Address) 41 Thornton Park, 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)
Director of Public Health 11/22/65
(Official Designation) (Date of Issue of Permit)

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 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

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

STANDARD
CERTIFICATE OF DEATH

Registered No. 261

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH MAX KAPLAN

(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. 235 Washington Avenue
(Usual place of abode)

St. Winthrop
(City or town and State)

Length of stay: In place of death.....years.....months17days. In place of residence11years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 21 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN 5, 1960, to NOV 21, 1965
I last saw him alive on NOV 21, 1965, death is said to
have occurred on the date stated above, at 9:20 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 DISEASE

5 YRS

Due To (c) GENERAL ARTERIO-SCLEROSIS

5 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

(Signature) Myron H. King, M. D.

MYRON H. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST. Winthrop, Mass. Date NOV 21 1965

6 BETH ISRAEL CEM., West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 23 1965

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service

ADDRESS 151 Washington Ave., Chelsea

Received and filed NOV 22 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced
HUSBAND of Mary Richmond
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE 75 Years 11 Months 7 Days If under 24 hours
Hours Minutes

13 Usual Occupation Broker
(Kind of work done during most of working life)

14 Industry or Business Insurance Agency

15 Social Security No. 033-26-4199

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Louis Kaplan

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Rebecca LINDER

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Mary Richmond Kaplan (Wife)

Inc. (Address) 235 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:

Paul C. Gaffney, Jr.
(Signature of Agent of Health or other)
Director of Public Health
(Official Designation) 11/23/65
(Date of Issue of Permit)

A TRUE COPY ATTEST:

Suffolk

Winthrop

Bay View Nursing Home

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE..... JOSEPH MAX KAPLAN

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

Married..... Male..... White.....

Mary Richmond

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 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 term, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



NOV 23 1965

November 23 1965
Tott Funeral Service Inc.
151 Washington Ave., Chelsea

Mary Richmond Kaplan (Wife)
335 Washington Ave., Winthrop

Rebecca

Russia

Russia

Insurance Agency
033-26-4122

broker

Louis Kaplan

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 262

Suffolk

(County)

Winthrop, Mass.

(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 Helen E. Splaine

(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) Permanent Residence. No. 175 Winthrop St., Winthrop, Mass.

(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 November 21 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Nov. 20 to Nov. 21, 1965

I last saw her alive on Nov. 20, 1965, death is said to have occurred on the date stated above, at 4:10 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intestinal Obstruction

INTERVAL BETWEEN ONSET AND DEATH 7 days

Due To (b) Ventral hernia at Colostomy site 4 1/2 yrs

Due To (c) Carcinoma of Rectum 4 1/2 yrs

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease 5 yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical + Lab.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) M. Traustein M. D.
M. TRAUSTEIN JR. M.D.
(Print or Type Name)

(Address) 73 Bartlett Rd. Winthrop Date Nov 21, 1965

6 Holy Cross Malden Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 23 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed NOV 22 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of James E. Splaine (Husband's name in full)

12 AGE 86 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. Warren Mass

16 BIRTHPLACE (City) Warren Mass (State or country)

17 NAME OF FATHER William Clarke

18 BIRTHPLACE OF FATHER (City) Ware Mass (State or country)

19 MAIDEN NAME OF MOTHER Margaret Calahan

20 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country)

21 Informant Peter Princi Att'y

(Address) 40 Court St. Boston, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (Signature of Agent of Board of Health or other)
Director of Public Health 11/22/65
(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.

NOV 22 1965 PM



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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

WINTHROP

PLACE OF DEATH

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

STANDARD

CERTIFICATE OF DEATH

Registered No.

263

THOMAS W. KEATING

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

10 WAVE WAY AVE.

WINTHROP MASS.

(a) Permanent Residence. No. St. (City or town and State)

Length of stay: In place of death.....years.....months.....3.....days. In place of residence.....14.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV 24 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from JAN 1963 to NOV 24 1965
I last saw him alive on NOV 24 1965 death is said to have occurred on the date stated above, at 4:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

(b) CARCINOMA OF PANCREAS

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH
8 MO
1 YR.OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? NO.

What test confirmed diagnosis? BIOPSY & CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) MYRON N. KING, M.D.

(Print or Type Name)

(Address) 22 PLEASANT ST WINTHROP MASS Date 11-24-1965

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 27 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed NOV 26 1965 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Janice Smith
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 48 Years 8 Months 17 Days If under 24 hours Hours Minutes

13 Usual Occupation Stationary fireman
(Kind of work done during most of working life)

14 Industry or Business: Foundry

15 Social Security No. 032-01-0250

16 BIRTHPLACE (City) Last Boston
(State or country) Mass

17 NAME OF FATHER Thomas E Keating

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Louise McGilvray

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant Janice Keating

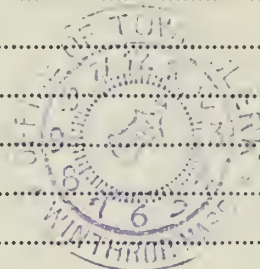
(Address) 10 Wave Way Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health 11/26/65
(Official Designation) (Date of Issue of Permit)

763

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

NOV 26 1965 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

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
 Winthrop
 (City or Town)



STANDARD
 CERTIFICATE OF DEATH

Registered No.

264

No. Winthrop Community Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Alfred J Thorburn
 (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) Permanent Residence. No. 14 Victoria St. Revere Mass
 (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 November 24 1965
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Nov 19, 1965, to November 24, 1965

I last saw him alive on November 23, 1965, death is said to have occurred on the date stated above, at 1:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Artery Disease

(b) Due To Arteriosclerosis

(c) Due To

OTHER SIGNIFICANT CONDITIONS NONE

INTERVAL BETWEEN ONSET AND DEATH

5 Days

5 yrs

Was autopsy performed? NO

What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased NO
 If so, specify

(Signature) John F. Collins MD, M. D.

(Print or Type Name)

(Address) Revere Mass Date Nov 24 1965

6 Green Ridge North Dover
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 27, 1965 19

7 NAME OF FUNERAL DIRECTOR Murray & Murray

ADDRESS Revere Mass.

Received and filed Nov. 24, 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (If married, give name of wife in full) Hattie Mable

(or) WIFE of (Husband's name in full)

12 AGE 4 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation School teacher (Kind of work done during most of working life)

14 Industry or Business City of Revere

15 Social Security No. 016-20-0563

16 BIRTHPLACE (City) New Jersey (State or country)

17 NAME OF FATHER George J. Thorburn

18 BIRTHPLACE OF FATHER (City) Mass. (State or country)

19 MAIDEN NAME OF MOTHER Hattie Mable

20 BIRTHPLACE OF MOTHER (City) Maine (State or country)

21 Informant Milton Thorburn

(Address) 23 Jacobs Rd. Southbridge

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gallway (B)
 (Signature of Agent of Board of Health or other)

Director of Public Health 11/24/65
 (Official Designation) (Date of Issue of Permit)

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.

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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

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

265

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No.

No. MAYFLOWER NURSING HOME

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. GAETANO CAPONE
(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. 196 RIVER RD. St.
(Usual place of abode)

Length of stay: In place of death.....years.....months.....4.....days. In place of residence.....25.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 26 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Oct. 6, 1965 to Nov. 26, 1965I last saw him alive on Nov. 24, 1965, death is said to
have occurred on the date stated above, at 4:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of colon

INTERVAL
BETWEEN
ONSET AND
DEATH

4 weeks

Due To (b) Adenocarcinoma
of colon

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph Gregorie M.D.

(Address) 194 Wash. Ave. Date 11/28/65

(Address) Winthrop Winthrop Mass

Place of Burial or Cremation Nov 29 1965

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St. Winthrop

Received and filed NOV 29 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
or DIVORCED10a If married, widowed, or divorced Marie Puzzo
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 10 Months 25 Days If under 24 hours
Hours Minutes13 Usual Occupation: Steelworker
(Kind of work done during most of working life)

14 Industry or Business: Steel Mfg.

15 Social Security No. 028-03-4021

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER ? Capone

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Angelina ?

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Maria Capone
(Address) 196 River Rd, 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)

Director of Public Health 11/28/65
(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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RECEIVED



NOV 29 1965 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop, Mass.
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 266

PLACE OF DEATH

Winthrop, Mass.
(County)Winthrop, Mass.
(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. Pauline Laub Groman
(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) Permanent Residence. No. 31 Coral Ave., Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 14 years 20 months 20 days. In place of residence 20 years 20 months 20 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 26, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 19, 55, to Nov. 26, 1965I last saw h. alive on Nov. 26, 1965 death is said to
have occurred on the date stated above, at 3:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of stomach

INTERVAL
BETWEEN
ONSET AND
DEATH

10 months

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

None

Was autopsy performed?

What test confirmed diagnosis? Clinical, Surgical, Pathological

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 11/26/1965

6 Tereeth Israel of Winthrop - Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 28 1965

7 NAME OF FUNERAL DIRECTOR ROBERT LeVine

ADDRESS 1468 BEACON ST BRUCLINE

Received and filed NOV 29 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of Leo LAUB
(Give maiden name of wife in full)
(Husband's name in full)12 AGE 58 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) LITHUANIA
(State or country)

17 NAME OF FATHER Resach Groman

18 BIRTHPLACE OF FATHER (City) LITHUANIA
(State or country)

19 MAIDEN NAME OF MOTHER TRINA BARON

20 BIRTHPLACE OF MOTHER (City) LITHUANIA
(State or country)

21 Informant DAVID GROMAN

(Address) 222 GROVERS Ave WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Paul C. Goffney)

(Signature of Agent of Board of Health or other)

Director of Public Health - 11/28/65
(Official Designation) (Date of Issue of Permit)

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 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



NOV 29 1965 PM

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ONS

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TYPE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 267

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 100 Quincy Avenue
Blanche

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Alice E. Williamson (Chamberlain)
(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) Permanent Residence. No. 100 Quincy Avenue s. Winthrop, Massachusetts
(Usual place of abode) (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 November 26 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov. 19 69 to Nov. 26 19 65
I last saw he alive on Nov. 2 19 65 death is said to
have occurred on the date stated above, at 3:00 A.M.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
to natural causes.

Due To Winthrop Board of Health
(b) (c)

OTHER SIGNIFICANT CONDITIONS Charles Liberman M.D.

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

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 11/26/19 65
(Print or Type Name)

6 Welcome O. Brown Cemetery Barton
Place of Burial or Cremation (City or Town) Vermont

DATE OF BURIAL November 30, 1965 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed NOV 29 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Harry Oscar Williamson
(Husband's name in full)

12 AGE 89 Years 3 Months 17 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 023-10-6767-B

16 BIRTHPLACE (City) North Troy
(State or country) Vermont

17 NAME OF FATHER Ezro Chamberlain

18 BIRTHPLACE OF FATHER (City) Vermont
(State or country)

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) Vermont
(State or country)

21 Informant Howard F. Coburn

(Address) 131 Nichols St. Wilmington

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney Jr.
(Signature of Agent of Board of Health or other)
Director of Public Health NOV 29 1965
(Official Designation) (Date of Issue of Permit)

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 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 29 1965 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 268

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 JOHN S. DALY
(If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW11(a) Permanent Residence. No. 76 SUNNYSIDE AVENUE St. WINTHROP, MASS.
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....29 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 30 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from JAN 5, 1957 to Nov 30, 1965

I last saw him alive on Nov-30, 1965, death is said to have occurred on the date stated above, at 1:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO SCLEROTIC HEART DISEASE & CONGESTIVE FAILURE 5 YRS

(b) Due To GENERAL ARTERIO SCLEROSIS 5 YRS

(c) Due To NEPHROSCLEROSIS - 1 YR.

OTHER SIGNIFICANT CONDITIONS BUNDLE BRANCH BLOCK MYOCARDIAL INFARCTION 5 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(Signature) Myron N. King M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 110 PLEASANT ST WINTHROP, MASS. Date 11/30 1965

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 3, 1965

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS Winthrop

Received and filed DEC 2 1965 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced HUSBAND of Dorothy E (Gaddis) Daly
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 62 Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation Customs Inspector
(Kind of work done during most of working life)

14 Industry or Business: U.S. Customs Service

15 Social Security No. 026-22-5249

16 BIRTHPLACE (City) Boston, Mass
(State or country)

17 NAME OF FATHER M. Thomas Daly

18 BIRTHPLACE OF FATHER Boston, Mass.
(City) (State or country)

19 MAIDEN NAME OF MOTHER Mary J. Dunncliffe

20 BIRTHPLACE OF MOTHER Boston, Mass.
(City) (State or country)

21 Informant Mrs. Dorothy Daly

(Address) 76 Sunnyside 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:

Paul C. Giffney, Director of Public Health
(Signature of Agent of Board of Health or other)Director of Public Health Dec 2 1965
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

SPACE FOR ADDITIONAL INFORMATION

C# 9-349-715

DATE OF ENTERING MILITARY SERVICE.....

May 13, 1942

DATE OF DISCHARGE.....

April 30, 1945

RANK, RATING

Capt.

ORGANIZATION AND OUTFIT.....

Army Trans. Corps

SERVICE NUMBER.....

032-18-72

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 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



DEC - 2 1965 AM

PLACE OF DEATH

1

(County)

(City or Town)

No.



The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

SEE DELAYED RETURN OF DEATHS BK.#1

Dep.#1

WINTHROP

(City or town making return)

Registered No.

#269

DELAYED RETURN OF DEATH

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL 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)

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

(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.....m.

Interval
Between
Onset and
Death

DISEASE OR CONDITION
DIRECTLY LEADING
TO DEATH (a)

ANTE Due To
CEDENT (b)
CAUSES

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Major findings:
Of operations

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....

If so, specify

(Signed)

M. D.

(Address)

Date

19.

6

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

19.

7 NAME OF
FUNERAL DIRECTOR

ADDRESS

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

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

Years

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)

(State or country)

17 NAME OF
FATHER

18 BIRTHPLACE OF

FATHER (City)

(State or country)

19 MAIDEN NAME

OF MOTHER

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Received and filed

19.

(Registrar)

AFFIDAVIT

WRITE LEGIBLY WITH DURABLE BLACK INK

The Commonwealth of Massachusetts }
County of..... } ss.:

The undersigned, being duly sworn, depose and say that the record relating to the death
ofin the.....of.....,
(Give name of decedent exactly as recorded on the original evidence) (City or town) (Name of city or town)
has not been previously recorded, and that the true statement of facts has been supplied by
..... on the form of certificate on the other side of this blank.
(Him or her)

SIGNATURE

RESIDENCE
(City or town, street and number, if any)

Spouse or heirs-at-law

FURTHER, The written evidence submitted to substantiate the affidavit was:

Proof of Domicile (Chap. 46 Sec. 1C.)

Date,.....

Then personally appeared before me the person whose signature appear above and made
oath that the statements subscribed to by.....are true.

Name

Official designation
(City or town clerk or assistant clerk)

MARGIN RESERVED FOR BINDING

OUT - OF - TOWN.

FORM R-301

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts

 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

270

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 07820

No. MASSACHUSETTS GENERAL HOSPITAL

{(If death occurred in a hospital or institution, give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

 2 FULL NAME Max Boyer
 (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) Permanent Residence. No. 11 Wave Way

St. Winthrop, Massachusetts

(City or town and State)

Length of stay: In place of death years months 16 days. In place of residence 28 years months days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH August 3, 1965
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 18, 1965, to August 3, 1965.

I last saw him live on August 3, 1965, death is said to have occurred on the date stated above, at 4:03 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL BETWEEN ONSET AND DEATH

(a) Ruptured Abdominal Aneurysm 2 wks

Due To

(b) Arteriosclerosis

Years

Due To

(c) Status Post-op resection

2 wks

aneurysm

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

(Signature) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date August 3, 1965

 6 MT. LEBANON W. ROX
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 4, 1965

7 NAME OF FUNERAL DIRECTOR ARNOLD Golov

ADDRESS 1668 Beacon St. Brookline

Received and filed AUG 5, 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

 Male White MARRIED
 WIDOWED
 DIVORCED
 UNKNOWN

 11 If married, widowed, or divorced HUSBAND of Betty GOLDBERG
 (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 52 Years Months Days If under 24 hours Hours Minutes

 13 Usual Occupation Used CAR Dealer
 (Kind of work done during most of working life)

14 Industry or Business Self EMPLOYED

15 Social Security No 033-16-8204

 16 BIRTHPLACE (City) BOSTON MASS
 (State or country)

17 NAME OF FATHER NATHAN BOIARSKY O.K.

 18 BIRTHPLACE OF FATHER (City) RUSSIA
 (State or country)

19 MAIDEN NAME OF MOTHER REBECCA AZOFF

 20 BIRTHPLACE OF MOTHER (City) RUSSIA
 (State or country)

21 Informant BETTY BOYER

(Address) 11 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:
 F.P. Giacca C 14057
 (Signature of Agent of Board of Health or other)

 (Official Designation) Aug 4, 1965
 (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
Clerk Registrar



NOV 24 1965 AM

A5
FORM R-301
1-7

and for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ra than one
se for each
(a), (b) and (c)

does not mean
ode of dying,
is heart failure,
a, etc. It means
eases, or compli-
which caused

ditions, 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

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81
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23 1965

45-939763

PLACE OF DEATH

Suffolk

(County)

West Roxbury

(City or Town)

No. Veterans Administration Hospital

2 FULL NAME Walter Thomas Erskine
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 93 Lexington St. East Boston, Mass.
3 hours 12 minutes
(City or town and State)

Length of stay: In place of death 0 years 0 months 0 days. In place of residence 78 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 28 1965
(Month) (Day) (Year)
4 I HEREBY CERTIFY, That I attended deceased from 9/28 1965, to 9/28 1965

death is said to have occurred on the date stated above, at 1:42 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial infarction

(b) Due To Arteriosclerotic heart disease

(c)

OTHER SIGNIFICANT CONDITIONS Diabetes

Was autopsy performed? yes

What test confirmed diagnosis? serum enzymes

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Scott Murphy M. D.
(Print or Type Name)

(Address) VAH W. Roxbury, Mass. 9/29/ 65

Winthrop Cemetery, Winthrop, Mass.

6 Place of Burial or Cremation (City or Town)
DATE OF BURIAL October 1 1965

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Funeral

ADDRESS 917 Bennin gton St., E. Boston,

Received and signed William J. Leone OCT 4 1965 19

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered 09652

(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, WW1 if so specify UNKNOWN)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Thelma Anderson (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 78 Years 11 Months 16 Days If under 24 hours Hours Minutes

13 Usual Occupation Marine Engineer (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 017 18 3086

16 BIRTHPLACE (City) Bath, Maine (State or country)

17 NAME OF FATHER Frederick Erskine

18 BIRTHPLACE OF FATHER (City) Wiscasset, Maine (State or country)

19 MAIDEN NAME OF MOTHER Margaret Butler

20 BIRTHPLACE OF MOTHER (City) Pittsburg, Maine (State or country)

21 Informant VA Hospital Records Home address West Roxbury, Mass.

MASSHEREBY CERTIFY that a satisfactory standard certificate of death has been issued 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)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar



DEC 23 1965 AM

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE,
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

272

(City or Town making this return)

FORM R-301

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 09636

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)

No

2 FULL NAME Philomena Principe

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 170 Cliff Ave.

St. Winthrop, Massachusetts

(City or town and State)

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 September 28, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Sept. 19, 1965, to September 28, 1965.

I last saw her live on September 28, 1965, death is said to

have occurred on the date stated above, at 10:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia

(b) Urinary Tract Infection

(c) Cerebral
Multiple Vascular AccidentsOTHER
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

(Signature) C. L. Clay, M.D.

(Print or Type Name) Charles L. Clay, M.D.

Sept. 28, 65

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date

6 St. Michael's Cemetery Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct-2 1965

7 NAME OF FUNERAL DIRECTOR Lillian Cataldo

ADDRESS 374 Broadway Som, Mass

Received and filed OCT 4 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE 73 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

15 Social Security No

16 BIRTHPLACE (City)

(State or country)

17 NAME OF FATHER

18 BIRTHPLACE OF FATHER (City)

(State or country)

19 MAIDEN NAME OF MOTHER

20 BIRTHPLACE OF MOTHER (City)

(State or country)

21 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)

Sept 30 - 1965

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

iled for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
ICAL CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
ause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
nia, etc. It means
disease, or compli-
s which caused

ditions, if any,
ich gave rise to
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to death but not
d to the terminal
e condition given

M.C.

331
70
33 1965

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ACK Ink.

05-64-938000

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



DEC 23 1965 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 609 270

PLACE OF DEATH

Suffolk
(County)Chelsea
(City or Town)

No. Chelsea Memorial Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}2 FULL NAME Axel (Alex) Carlson
(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. Cliff Nursing Home, 170 Cliff Ave., Winthrop, Mass.
(Usual place of abode) (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 Nov. 13, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
June 10/63, to Nov. 13, 1965
I last saw him live on Nov. 7, 1965, death is said to
have occurred on the date stated above, at 12:10 A.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage 2 hrs.

Due To (b) Cerebral arteriosclerosis 5 yrs.

(c) Carcinoma of prostate 18 mos.

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? no
What test confirmed diagnosis? clinical5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) William P. Finnegan, M. D.

(Address) 647 Broadway, Chelsea, Mass.
Date 11/15/656 Woodlawn, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 15, 1965

7 NAME OF FUNERAL DIRECTOR J. E. McGlinchey Fun. Home

ADDRESS 583 Broadway, Chelsea, Mass.

DEC 28 1965

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
WIDOWED
DIVORCED
UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 80 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Machinist
(Kind of work done during most of working life)

Industry or Business:

15 Social Security No. 023-10-2325

16 BIRTHPLACE (City)
(State or country) Sweden

17 NAME OF FATHER Victor Carlson

18 BIRTHPLACE OF FATHER (City)
(State or country) Sweden

19 MAIDEN NAME OF MOTHER Anna (cannot be learned)

20 BIRTHPLACE OF MOTHER (City)
(State or country) Sweden

21 Informant George R. Morse, Chelsea, Mass.

(Address) Public Welfare Dept.

A TRUE COPY

ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED Nov. 15, 1965

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.

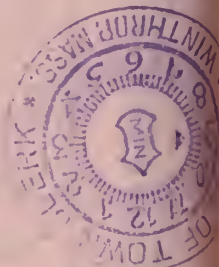
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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 28 1965 AM



RECEIVED

PLACE OF DEATH

Essex

(County)

Saugus

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Saugus

(City or Town making this return)

Registered No. 220 274

No. D.O.A. Saugus General Hospital. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Winthrop J. Colson

(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 & 2

(a) Residence No. 294 Bowdoin St.
(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 1.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 30, 1965
(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 thrombosis-Sudden Death.

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?

(Specify type of place)

Manner of
Injury

(How did injury occur?)

Nature of
Injury

No

No

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph A. DiClerico M. D.

(Address) Lynn, Mass. 11/30 65

7 Winthrop Cemetery, Winthrop
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL December 3, 65

8 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed DEC 13 1965

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

12 If married, widowed, or divorced
HUSBAND of Grace McAuley
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 66 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation Retired U. S. Employee
(If kind of work done during most of working life)

15 Industry or Business: U. S. Postal Dep't.

16 Social Security No.

17 BIRTHPLACE (City) Winthrop
(State or country) Mass.

18 NAME OF FATHER

19 BIRTHPLACE William W. Colson
FATHER (City) Boston
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Mass.

21 BIRTHPLACE Genieva Grady
MOTHER (City) Boston
(State or country) Mass.

22 Informant Grace Colson
(Address) 294 Bowdoin St., Winthrop

A TRUE COPY

ATTEST: William D. Robinson
(Registrar of City or Town where death occurred)

DATE FILED Dec. 2, 1965

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 9/10/42

DATE OF DISCHARGE 1/3/46

RANK, RATING 1 Cl.

ORGANIZATION AND OUTFIT U. S. N.

SERVICE NUMBER 122 15 26



DEC 13 1965 AM

The Commonwealth of Massachusetts

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

Volunteer - 21 HUSBAND

2 FULL NAME

ELEANOR VELLANTE (CIPRIANI)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 81 WINTHROP ST.

St. WINTHROP

MASS.

(City or town and State)

Length of stay: In place of death.....years.....1.....months.....5.....days. In place of residence.....3.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DECEMBER 8 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Nov 3, 1964, to Dec 8, 1965.

I last saw her alive on December 7, 1965, death is said to have occurred on the date stated above, at 12:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

Due To (b) Lung carcinoma of

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Joseph Gregorie, M. D.

JOSEPH GREGORIE

(Print or Type Name)

(Address) 19 Washington St. Date 12-8 1965

6 WINTHROP WINTHROP

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Dec 11 1965

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Wintthrop St Wintthrop

Received and filed DEC 13 1965

A TRUE COPY ATTEST:

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

275

(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

DIVORCED

UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

ALBERT Z VELLANTE

(Husband's name in full)

12

AGE 36 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.

16 BIRTHPLACE (City)

Reading

(State or country) Mass

17 NAME OF

FATHER

Victor Cipriani

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

Louise DeSantes

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Franklin

Mass

21 Informant Albert Z Vellante

(Address) 81 Wintthrop St Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gregory (a)

(Signature of Agent of Board of Health or other)

Director of Public Health Dec 10 1965

(Official Designation)

(Date of Issue of Permit)

V.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.

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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.

DEC 15 1965 PM



burial permit
of Health
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 276

No. 253 Washington Ave
Rose Simonelli (Conti)

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

ALL 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) Re No. 253 Washington Ave. St. Winthrop
(c) place of abode (City or town and State)

Length of stay: 49 years 49 months 49 days. In place of residence 49 years 49 months 49 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec 10, 1965
(Month) (Day) (Year)
4 I HEREBY CERTIFY, That I attended deceased from
19....., 19....., to....., 19.....
I last saw him alive on....., 19....., death is said to
have occurred on the date stated above, at 5:30 p.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death - presumably

(b) due to natural causes.

Due To Winthrop Board of Health
(c) Charles Liberman, M.D.

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

(Signature) Charles Liberman, M.D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) Winthrop, Mass. Date 12/13/1965

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 15, 1965

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St, Winthrop

Received and filed DEC 14 1965

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, wife, or divorced
HUSBAND of Louie Simonelli
(Give maiden name of wife in full)

(or) WIFE of Louie Simonelli
(Husband's name in full)

12 AGE 87 Years 9 Months 5 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 Angelo Conti

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Agata Lazara

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mrs Rose Simonelli

(Address) 253 Washington Ave

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney, Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health 12/14/65
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Medical Examiner Notified - Referred to Board of Health

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 the 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.



burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **277**

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. **WINTHROP COM. HOSP**

2 FULL NAME **MASQUALE GIGLIO**
(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, **NO**
if so specify WAR)

(a) Permanent Residence, No. **17 BELLE ISLE AVE**
(Usual place of abode)

St. **REVERE**

(City or town and State)

Length of stay: In place of death.....years.....months.....**7** days. In place of residence **25** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 13 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Sept. 1964, to **Dec. 13 1965**
I last saw him live on **Dec. 13 1965** death is said to
have occurred on the date stated above, at **10:55 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **myocardial heart disease**(b) **arteriosclerosis - gen.**(c) **Senility**

INTERVAL
BETWEEN
ONSET AND
DEATH

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

(Signature) **Joseph S. [illegible]** M. D.

(Print or Type Name)

(Address) **WINTHROP** Date **12-13 1965**

6 **MT BENEDICT.** **BOSTON**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **DEC 15 1965**

7 NAME OF FUNERAL DIRECTOR **MAURICE W. KIRBY**

ADDRESS **WINTHROP.**Received and filed **DEC 15 1965** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN **MARRIED**

11 If married, widowed, or divorced
HUSBAND of **LOUISA MARAZZA**
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE **80** Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation **TAILOR - Retired**
(Kind of work done during most of working life)

14 Industry or Business **CLOTHING FACTORY**

15 Social Security No.....

16 BIRTHPLACE (City) **ITALY**
(State or country)

17 NAME OF FATHER **MICHAEL GIGLIO**

18 BIRTHPLACE OF FATHER (City) **ITALY**
(State or country)

19 MAIDEN NAME OF MOTHER **MADEIRA (UNKNOWN)**

20 BIRTHPLACE OF MOTHER (City) **ITALY**
(State or country)

21 Informant **LOUISA GIGLIO**
(Address) **17 BELLE ISLE AVE, REVERE**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney, Jr.

(Signature of Agent of Board of Health or other)

Director of Public Health **Dec 14 1965**

(Official Designation)

(Date of Issue of Permit)

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:

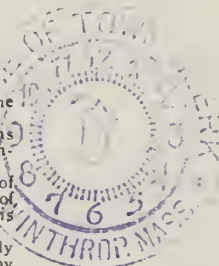
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

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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.



DEC 15 1965 AM

R-301

burial permit
of Health
Agent.

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4553

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

2 FULL NAME

Mary L (Heavner) Reed

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

50 Siren Street

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death 3 years months days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

DEC

13

1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased, from July 1962, to DEC 13 1965

I last saw him live on DEC 3 1965, death is said to have occurred on the date stated above, at 7:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) NEPHROSCLEROSIS

Due To

GENERAL ARTERIOSCLEROSIS

(b)

ARTERIO SCLEROTIC HEART DISEASE

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

(Signature)

Myron N. King

M. D.

MYRON N. KING M.D.

(Address)

22 Pleasant St.

Date 12/13 1965

Woodlawn Crematory

Everett

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Dec. 15

1965

7 NAME OF

FUNERAL DIRECTOR

Howard S Reynolds

ADDRESS

Winthrop, Mass.

Received and filed

DEC 14 1965

19

DEC 14 1965

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

278

(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

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widow

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

William Reed

(Husband's name in full)

12

AGE

96

Years

9

Months

12

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)

Boston

(State or country)

Mass

17 NAME OF

FATHER

Church Heavner

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Maine

19 MAIDEN NAME

OF MOTHER

Unable to obtain

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Maine

21 Informant

Lona Phillips

(Address)

50 Siren St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney

(Signature of Agent of Board of Health or other)

Director of Public Health

Dec 14 1965

(Official Designation)

(Date of Issue of Permit)

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.



DEC 14 1965 PM

Burial permit
of Health
Agent.

CTIONS
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 259

No. Cliff House Nursing Home

(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 **Lauretta (Jessop) Earl**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. 239 Pleasant Street
(Usual place of abode) 6

St. 30 (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 14, 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Aug. 17, 1957 to **Dec. 14, 1965**

I last saw him alive on **Dec. 10, 1965**, death is said to

have occurred on the date stated above, at **10:55 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Cerebral hemorrhage right
(a) **with left hemiparesis**

INTERVAL
BETWEEN
ONSET AND
DEATH

4 Days

Due To **Arteriosclerotic & hyper-**
(b) **tensive heart disease**

5 yrs

Due To **Generalized arterioscler-**
(c) **osis**

8 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

(Signature) **M. Traunstein Jr.**, M. D.

M. Traunstein, Jr., M. D.

(Address) **73 Bartlett Rd. Dec. 14, 65**
Winthrop, Mass. 02152

6 **Winthrop Winthrop**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **December 17, 1965**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop, Mass**

Received and filed **DEC 16 1965**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
Married
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of **Harry Earl**
(Husband's name in full)

12 AGE **77** Years **3** Months **10** 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) **Boston**
(State or country) **Mass**

17 NAME OF FATHER **John Jessop**

18 BIRTHPLACE OF FATHER (City) **Boston**
(State or country) **Mass**

19 MAIDEN NAME OF MOTHER **Mary E Rourke**

20 BIRTHPLACE OF MOTHER (City) **Cambridge**
(State or country) **Mass**

21 Informant **Harry Earl**
(Address) **239 Pleasant 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:

Paul C. Gaffney (s)
(Signature of Agent of Health or other)
Director of Public Health (Official Designation)
Dec 16, 1965 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



DEC 16 1965 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.

PLACE OF DEATH

Middlesex

(County)

Tewksbury, Mass.

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Tewksbury Hospital

(City or Town making this return)

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No. **233-280**No. **Tewksbury Hospital**{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME **Erminio Vecchia**

(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. **32 Irvin St.**
(Usual place of abode)St. **Winthrop, Mass.**

(If nonresident, give city or town and State)

Length of stay: In place of death **6** years **6** months **19** days. In place of residence **6** years **6** months **19** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 14, 1965**

(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.)

**Generalized arteriosclerosis
Fracture of left humerus**5 Accident, suicide, or homicide (specify) **accident**Date and hour of injury **an Dec. 14** 19**65**IF ACCIDENTAL, was injury causally related to the death? **no**Where did
Injury occur? **Tewksbury**
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in
public place? **State Hospital**
(Specify type of place)Manner of
Injury **unknown**
(How did injury occur?)Nature of
Injury **above**While at work? **No** Was autopsy performed? **No**6 Was disease or injury in any way related to occupation of deceased? **No**

If so, specify

(Signed) **John Karbowniczak**, M. D.
John Karbowniczak M.D.(Address) **465 High St., Lowell 12/14**
St. Michaels Cem., Boston, Mass.7 Place of Burial or Cremation **12/18** (City or Town) **65**DATE OF BURIAL **12/18** 19**65**8 NAME OF FUNERAL DIRECTOR **Anthony P. Rapino**ADDRESS **9 Chelsea St., E. Boston, Mass.**Received and filed **JAN 10 1966** 19**65**

(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
DIVORCED
UNKNOWN

12 If married, widowed, or divorced

HUSBAND of **Concetta Grandi**

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 **74**AGE **74** Years **6** Months **19** Days

If under 24 hours

6 Hours **19** Minutes

14 Usual

Occupation: **Railroad worker**

(Kind of work done during most of working life)

15 Industry

or Business: **Railroad**

16 Social Security No.

706-07-0794

17 BIRTHPLACE (City)

(State or country) **Florence**
Italy

18 NAME OF

FATHER

Crescenzo VecchiaP
A
R
E
N
T
S

19 BIRTHPLACE OF

FATHER (City)

(State or country) **cannot be learned**
Italy

20 MAIDEN NAME

OF MOTHER

Eleanora Boniello

21 BIRTHPLACE OF

MOTHER (City)

(State or country) **cannot be learned**
Italy

22

Informant

(Address)

Hospital Records & Son**Christopher**

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

12/1419**65**

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



JAN 10 1966 AM

burial permit
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SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 281

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 MARGARET M. WILSON (McGlinchey)
(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. 827 SHIRLEY STREET
(Usual place of abode)

St. WINTHROP

(City or town and State)

Length of stay: In place of death 1 years 6 months days. In place of residence 6 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC. 14, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
June 12, 1964 to Dec. 14, 1965
I last saw her alive on Dec. 1, 1965 death is said to
have occurred on the date stated above, at 9:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction 2 HRS.

(b) Due To Atherosclerotic Heart Disease 3 YRS.

(c) Generalized Atherosclerosis 5 YRS.

OTHER SIGNIFICANT CONDITIONS Subclavian Phlebitis Rt. Leg 1 month

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

(Signature) M. Traubstein, M. D.

(Print or Type Name) M. TRAUBSTEIN, M.D.

(Address) 73 Bartholomew St. Wintrop Date 12/14/65

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 12/17/65 1965

7 NAME OF FUNERAL DIRECTOR JOHN F. WARD & SON

ADDRESS 772 BROADWAY, EVERETT

Received and filed DEC 15 1965 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED
DIVORCED UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of CHARLES P. WILSON
(Husband's name in full)12 AGE 91 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. 010-30-9246

16 BIRTHPLACE (City) CAMBRIDGE, MASS.
(State or country)

17 NAME OF FATHER JAMES MCGLINCHY

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER ANN McDONALD

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant DOROTHY M. MAHONEY

(Address) 827 SHIRLEY AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Gaffney
(Signature of Agent of Board of Health or other)
Director of Public Health 12/15/65
(Official Designation) (Date of Issue of Permit)

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.

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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
MEDICAL EXAMINER DECLINES JURISDICTION

10M-6-62-933404



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.

SUFFOLK

(County)

WINTHROP

(City or Town)

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

Registered No. 282

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 STILLBORN FEMALE NEWELL
(if given)

3 DATE OF DELIVERY DEC 15 1965

(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

Unknown

FATHER

14 MAIDEN NAME

MOTHER CAROL NEWELL

PRESENT NAME

CAROL NEWELL

9 RESIDENCE, NO.
CITY OR TOWN

STREET

STATE

15 RESIDENCE, NO. 29 TAFTS AVENUE
CITY OR TOWN WINTHROP

STREET MASS.

10 COLOR OR RACE

11 AGE AT TIME OF THIS DELIVERY (Years)

16 COLOR OR RACE W

17 AGE AT TIME OF THIS DELIVERY 22 (Years)

12 PLACE OF BIRTH

(City or Town)

(State or country)

18 PLACE OF BIRTH ROCKPORT

MASS.

(City or Town)

(State or country)

13 OCCUPATION

19 INFORMANT

Carol Newell

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

ONE

(a) How many children are now living?

ONE

(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 completed weeks 20

22 Weight OF FETUS (or) Oz 3 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)

PREMATURE LABOR

Due To (b)

CAUSE UNDETERMINED

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 Place of Burial or Cremation Wintthrop

(City or Town)

DATE OF BURIAL

12/17/65

19

27 NAME OF FUNERAL DIRECTOR Ernest P. Baggiano

ADDRESS 147 Wintthrop St Wintthrop Mass

Received and filed

12-17-65

19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 6.52 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Myron N. King

M.D.

MYRON N. KING M.D.

(PRINT OR TYPE NAME)

Address 222 PLEASANT STREET WINTHROP MASS. Date 12/15 65 19

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (3)

(Signature of Agent of Board of Health or other)

Director of Public Health Dec 17, 1965

(Official Designation)

(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.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

Registered No. 283

STANDARD
CERTIFICATE OF DEATHNo. 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 DEAN, SOPHIE Blake
(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) Permanent Residence. No. 20 SARGENT ST. St. WINTHROP, MASS.
(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 December 17 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Feb. 1962 to 12/17/1965
I last saw her alive on 12/16/1965, death is said to
have occurred on the date stated above, at 12:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage 6 hrs.

(b) Due To Hypertension 5 yrs

(c) Due To

INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
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

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 12/17/1965

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 20, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed DEC 20 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)
MARRIED Single
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 74 Years 6 Months 24 Days If under 24 hours
Hours Minutes13 Usual Occupation Retired Clerk
(Kind of work done during most of working life)

14 Industry or Business Winthrop Water Dept.

15 Social Security No. 033-34-4008

16 BIRTHPLACE (City) Chelsea
(State or country) Massachusetts

17 NAME OF FATHER Alvan Hall Dean

18 BIRTHPLACE OF FATHER (City) Medford
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Sarah Webber

20 BIRTHPLACE OF MOTHER (City) Hallowell
(State or country) Maine

21 Informant Mrs. Zadok L. Stiles

(Address) 20 Sargent St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or burial permit was issued:Paul C. Gaffney
(Signature of Agent of Board of Health or other)
Director of Public Health Dec. 20, 1965
(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
CITY OF TOWSON
JAN 10 1950
DEPT. OF HEALTH
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 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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Woburn

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATHRegistered No. **284**{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PLACE OF DEATH

Middlesex

(County)

Woburn

(City or Town)

No. **Choate Memorial Hospital****ROBERT M. ALLEN**2 FULL 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) Permanent Residence. No.
(Usual place of abode)**27 Townsend****Winthrop, Mass.**

(City or town and State)

Length of stay: In place of death, years **1** months **1** days. In place of residence **50** years **50** months **50** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **DECEMBER 18, 1965**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov. 28, 1965 to **Dec. 18, 1965**
in **Dec. 17, 1965** death is said to
1 last saw him alive on **Dec. 17, 1965** at **5:30 A.**
have occurred on the date stated above, at **5:30 A.**DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Myocardial infarction(a) **Arteriosclerotic heart dis.**(b) **Arteriosclerotic heart dis.**OTHER SIGNIFICANT CONDITIONS **Myxedema**
TB (inactive) emphysemaINTERVAL
BETWEEN
ONSET AND
DEATH
2 daysWas autopsy performed? **no**
What test confirmed diagnosis? **ECG's**5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify(Signature) **Dr. Daniel Tassel**, M. D.(Address) **Burlington, Mass** Date **12-18-65**6 **Winthrop Cemetery** **Winthrop, Mass.**
Place of Burial or Cremation **DECEMBER 20, 1965**DATE OF BURIAL **1965**7 NAME OF FUNERAL DIRECTOR **Dello Russo Fun. Service**ADDRESS **306 Main St., Medford, Mass.**Received and filed **JAN 5 1966**

(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**
WIDOWED **UNKNOWN**11 If married, widowed, or divorced
HUSBAND of **Edith L. Erickson**
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 **62** Years **--** Months **--** Days If under 24 hours
AGE **62** Years **--** Months **--** Days **--** Hours **--** Minutes13 Usual Occupation: **Meat Cutter**
(Kind of work done during most of working life)14 Industry or Business: **Retired**15 Social Security No. **010-10-5127**16 BIRTHPLACE (City) **Manchester, Mass.**
(State or country)17 NAME OF FATHER **Robert L. Allen**18 BIRTHPLACE OF FATHER (City) **Scotland**
(State or country)19 MAIDEN NAME OF MOTHER **Margaret Milne**20 BIRTHPLACE OF MOTHER (City) **Scotland**
(State or country)21 Informant **Charlotte Dec (Daughter)**(Address) **59 Mill St., Milford, Mass.**

A TRUE COPY

ATTEST: **Margaret G. Lane**
(Registrar of City or Town where death occurred)DATE FILED **12-20-1965**

SPACE FOR ADDITIONAL INFORMATION

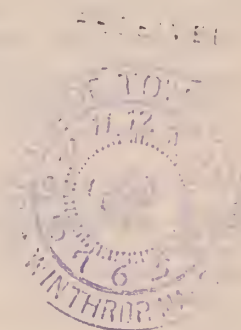
DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



JAN - 5 1966 AM

burial permit
of Health
Agent.

IONS

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terminal
ion givenReferred to Board of Health
Medical examiner notified.

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Mayflower Nursing Home

2 FULL NAME Anna L. Cullen
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 63 Chester Avenue
(Usual place of abode)St. (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.

(b) Length of stay: In place of death 3 years.....months.....days. In place of residence 60 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 19 1965
(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 1:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

(b) to natural causes.

(c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman M.D.

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles Liberman, M. D.

(Address) CHARLES LIBERMAN
(Print or Type Name)
WINTHROP MASS. Date 12/19/19656 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 22, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed DEC 21 1965

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 285

(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.

(b) Length of stay: In place of death 3 years.....months.....days. In place of residence 60 years.....months.....days.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED single
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 82 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. none

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Owen Cullen

18 BIRTHPLACE OF FATHER (City) unknown
(State or country)

19 MAIDEN NAME OF MOTHER Mary ?

20 BIRTHPLACE OF MOTHER (City) unknown
(State or country)

21 Informant Atty. Edward R. Thomas

(Address) 18 Tremont St. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Gaffney (mak)
(Signature of Agent of Board of Health or other)
Director of Public Health Dec 21 1965
(Official Designation) (Date of Issue of Permit)

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:

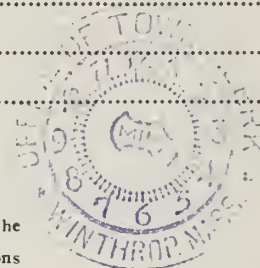
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DEC 21 1965 PM

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Mayflower Nursing Home

Anna Habelow

2 FULL NAME. (If deceased is a married, widowed or divorced woman, give also maiden name.)

104 Pleasant St.

(a) Residence. No.

(Usual place of abode)

St.

Brookline

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months 9 days. In place of residence. 25 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 19, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1965, to Dec. 19, 1965.

I last saw her alive on Dec. 19, 1965, death is said to have occurred on the date stated above, at 11:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Colon

INTERVAL
BETWEEN
ONSET AND
DEATH
1 yr.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

None

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 Liberman

M. D.

CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS Date 12/19/1965

6 Ahavas Achim of Revere Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 21, 1965

7 NAME OF

FUNERAL DIRECTOR

Morris W. Brezniak

ADDRESS

470 Harvard St. Brookline

Received and filed

Dec. 22, 1965

(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. 286

{(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 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

67

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:

Statistician

15 Social Security No.

1 NK 1000

16 BIRTHPLACE (City)
(State or country)

Boston, Mass.

17 NAME OF
FATHER

Michael Habelow

18 BIRTHPLACE OF

FATHER (City)

Russia

(State or country)

19 MAIDEN NAME

OF MOTHER

Fannie (unknown)

20 BIRTHPLACE OF

MOTHER (City)

Russia

(State or country)

21

Informant

(Address)

Mr. Habelow (Donald)

52 A. Harvard Ave. Brookline

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Paul C. Saffner
(Signature of Agent of Board of Health or other)Director of Public Health
(Official Designation)12/21/65
(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:

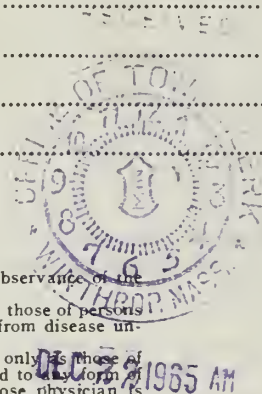
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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths 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.



KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No. 287

No. 26x Sturgis St., Bay View Nursing Home

(If death occurred in a hospital or institution, St. (give its NAME instead of street and number))

PHYSICIAN — IMPORTANT

2 FULL NAME Margaret Dolan
 (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. 50 Centre St.,
 (Usual place of abode)

St. (City or town and State)

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 DECEMBER 23 - 1965
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from JANUARY 1960 to DEC. 23 - 1965

I last saw her alive on 12-22-65, 19, death is said to have occurred on the date stated above, at 6 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC FAILURE

INTERVAL BETWEEN ONSET AND DEATH

1 DAY

(b) ARTERIOSCLEROTIC HEART DISEASE 10/4/65

(c) Due To

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

(Signature) A. N. Caplan, M. D.

A. N. CAPLAN MD

(Address) 186 PRINCETON ST. BOSTON at 12-23-65

6 Mt. Benedict West Roxbury
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 27 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed John A. Stark 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Single DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 87 Years Months 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

15 Social Security No.

16 BIRTHPLACE (City) England (State or country)

17 NAME OF FATHER John Dolan

18 BIRTHPLACE OF FATHER (City) England (State or country)

19 MAIDEN NAME OF MOTHER Ann Casey

20 BIRTHPLACE OF MOTHER (City) England (State or country)

21 Informant Frederick J. Muldoon

(Address) 1 Court St., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Gaffney (Signature of Agent of Board of Health or other)

Director of Public Health See 27, 1965 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



DEC 27 1965 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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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

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burial permit
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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 33 Underhill Street

Albert Segal

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 33 Underhill

Winthrop

Registered No. 288

(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 WARL)

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 26, 1965 (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 2:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

(b) Due To natural causes

(c) Due To Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? C

5 Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signature) Charles Liberman, M. D.

(Address) Winthrop, Mass. Date Dec 26, 1965

6 Tifereth Israel, Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 27, 1965

7 NAME OF FUNERAL DIRECTOR Torf Funeral Serv. Inc.

ADDRESS 151 Washington Ave., Chelsea

Received and filed DEC 27 1965

A TRUE COPY ATTEST

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or town making this return)

STANDARD
CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed or divorced HUSBAND of Bella Tenovsky (Give maiden name of wife in full) BESSIE

(or) WIFE of (Husband's name in full)

12 AGE 66 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Proprietor (Kind of work done during most of working life)

14 Industry or Business Wholesale & Retail Groceries

15 Social Security No. 034-20-9632

16 BIRTHPLACE (City) Russia (State or country)

17 NAME OF FATHER Joseph Segal

18 BIRTHPLACE OF FATHER (City) Russia (State or country)

19 MAIDEN NAME OF MOTHER Rose (CBL)

20 BIRTHPLACE OF MOTHER (City) Russia (State or country)

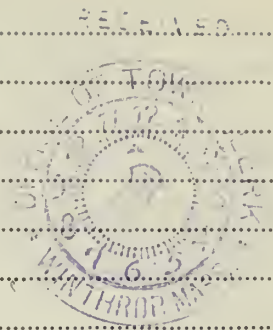
21 Informant Mr. George Segal 40 Lawrence St., Everett

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul C. Goffney (Signature of Agent of Board of Health or other) Director of Public Health Dec 27-1965 (Official Designation) (Date of Issue of Permit)

Medical Examiner Notified - Referred to Board of Health

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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FORM R-303

filed for burial permit
th Board of Health
th Its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

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, §§ 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.

100M-5-64-938000

SUFFOLK
(County)
BOSTON
(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

103889

Massachusetts General Hospital

No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME **MATTHEW****BLANKMAN**(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))**270 Shirley Street, Winthrop, Mass.**

(a) Permanent Residence. No.

40

(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 **October 23, 1965**
DEATH (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 arteriosclerosis.
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? **Yes**

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 Name)(Address) **Boston** Date **10/23/1965**7 **WOODLAWN CEM****EVERETT**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **OCT 25,** 19**65**8 NAME OF **SOLOMON FUNERAL HOME INC**
FUNERAL DIRECTOR
ADDRESS **420 HARVARD ST BROOKLINE**

Received and filed

OCT 26 1965

A TRUE COPY ATTEST

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX **MALE** 10 COLOR **WHITE** 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
MARRIED
UNKNOWN12 If married, widowed, or divorced **GLADYS JENKINS**
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 **52** AGE Years Months Days If under 24 hours
Hours Minutes14 Usual **DRY CLEANERS**
Occupation: (Kind of work done during most of working life)15 Industry or Business: **OWNER**

16 Social Security No.

17 BIRTHPLACE (City) **BOSTON MASS**
(State or country)18 NAME OF **DAVID BLANKMAN**
FATHER19 BIRTHPLACE OF **POLAND**
FATHER (City)
(State or country)20 MAIDEN NAME **SOPHIA (UNKNOWN)**
OF MOTHER21 BIRTHPLACE OF **POLAND**
MOTHER (City)
(State or country)22 **MRS MATTHEW A. BLANKMAN WIFE**Informant (Address) **270 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:**C16791 Kenneth W. Hurd**
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

1966

A TRUE COPY ATTEST:

William J. Kane.

City Registrar



FEB - 3 1966 AM

OUT - OF - TOWN

FORM R-301

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

to not enter
ore than one
ue for each
, (b) and (c)

does not mean
ade of dying,
s heart failure,
a, etc. It means
ase, or compli-
which caused

itions, if any,
s gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
a death but not
to the terminal
condition given

1966

Director
use only
K Ink.

4-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No.

10452

Massachusetts General Hospital BAKER MEMORIAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Leo A Gilleo

(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) Permanent Residence. No. 96 Woodside AveWinthrop Mass.

(City or town and State)

Length of stay: In place of death, years, months 1 days. In place of residence 23 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 23 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from October 22, 1965, to October 23, 1965I last saw him alive on October 23, 1965 death is said tohave occurred on the date stated above, at 5:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intracerebral hemorrhage unk hrs(b) Hypertensive Heart Disease unk yrs

(c)

OTHER SIGNIFICANT CONDITIONS Carcinoma of (R) Lung unkWas autopsy performed? YesWhat test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Ch. L. Clay, M.D.Charles L. Clay, M.D.
(Print or Type Name)(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct 23, 19656 Holy Cross Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL October 26, 19657 NAME OF FUNERAL DIRECTOR Leo M. NortonADDRESS 287 Main St. Malden Mass.Received and filed OCT 27 1965William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Married

11 If married, widowed, or divorced

HUSBAND of

Leona C. Gilleo

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE

62

Years

2

Months

19

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:

Oil Co.

15 Social Security No.

16 BIRTHPLACE (City)

East Boston

(State or country)

Mass.

17 NAME OF FATHER

Martin Gilleo

18 BIRTHPLACE OF FATHER (City)

(State or country)

P.E.I.

19 MAIDEN NAME OF MOTHER

Annie Dauncey

20 BIRTHPLACE OF MOTHER (City)

(State or country)

England21 Informant Mrs. Leona C. Gilleo(Address) 96 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:

Signe Howard C 16831

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



FEB - 3 1966 AM

FORM R-303

Filed for burial permit
with Board of Health
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

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.

100M-5-64-938000

1966

PLACE OF DEATH

1

Suffolk
(County)
Boston
(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

291

(City or Town making this return)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. **10388**

En route to Mass General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME *Aaron* *Levy* *Levy*
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence. No. *269A Shirley St. Winthrop Mass*
(City or town and State)

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 *October 23 1965*
(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
(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?

(Signed) *Michael H. Williams*, M. D.
(Printed Name)

(Address) *Boston* Date *10/23/1965*

7 **SHARON MEMORIAL PARK** **SHARON**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *OCT 25,* 19*65*

8 NAME OF FUNERAL DIRECTOR **SOLOMON FUNERAL HOME INC**
420 HARVARD ST BROOKLINE
ADDRESS

Received and filed *Oct 26 1965* 19.....

A TRUE COPY TEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)

MALE WHITE MARRIED

12 If married, widowed, or divorced **BESSIE MISKIN**
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE *70* If under 24 hours
Year Months Days Hours Minutes

14 Usual Occupation: **(RETIRED) PRODUCE DEALER**
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. *034-26-5216*

17 BIRTHPLACE (City) **BOSTON**
(State or country)

18 NAME OF FATHER **MORRIS LEVY**

19 BIRTHPLACE OF FATHER (City) **MAINE**
(State or country)

20 MAIDEN NAME OF MOTHER **RACHEL BLOCK**

21 BIRTHPLACE OF MOTHER (City) **NEW YORK CITY**
(State or country)

22 Informant **MRS AARON LEVY** **WIFE**
(Address) **269A 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:
C 16790 Kenneth W. Hand
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



FEB - 3 1966 AM

OUT - OF TOWN

The Commonwealth of Massachusetts

292

FORM R-301

Suffolk

(County)

Boston

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 10546

No. New England Center Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Rose (Jordan) GIORDANO

(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) Permanent Residence. No. Cliff Nursing Home St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months 3 days. In place of residence year 14 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 25 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from October 22 65 to October 25 65

I last saw her alive on October 25 1965, death is said to have occurred on the date stated above, at 2.00 pm.

DEATH WAS CAUSED BY IMMEDIATE CAUSE

(a) Perforated Sigmoid Colon
Perforated sigmoid colon

(b) with peritonitis

(c) Due To Mesenteric THROMBOSIS
mesenteric thrombosisOTHER
SIGNIFICANT
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH
40 DAYSWas autopsy performed? YES
What test confirmed diagnosis? Biopsy SURGERY5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Riccardo A. Curtone M. D.

(Address) NECA Date 10/25/65

6 ST. MICHAEL BOSTON
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT. 28 1965

7 NAME OF FUNERAL DIRECTOR DIPIETRO KVAZZA

11 HENRY ST. EAST BOSTON
ADDRESS

Received and filed OCT. 28 1965

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) HENRY GIORDANO (Husband's name in full)

12 AGE 80 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 030-3640046

16 BIRTHPLACE (City) ITALY (State or country)

17 NAME OF FATHER MICHAEL LUCCA

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 HENRY DIMINICO 853 SARATOGA ST. EAST BOSTON (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

C16942 Kenneth W. And

(Signature of Agent of Board of Health or other)

OCT. 27 1965

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

1966

A TRUE COPY ATTLST:

William J. Kane.
City Registrar

RECEIVED



FEB - 3 1966 AM

FORM R-301

for burial permit
Board of Health
City Agent.

INSTRUCTIONS
FOR
DEATH CERTIFICATE

TYPE OR TYPE
OR CAUSES
OF DEATH

do 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-
cation which caused

conditions, if any,
which gave rise to
the cause (a),
the under-
cause last.

conditions contrib-
ing to death but not
to the terminal
condition given

011
81
6-70

1966

65-939763

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

10648

Registered No.

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 BESSIE IZEN
(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) Permanent Residence. No. 9 WAVE WAY AVE. WINTHROP MASS
(City or town and State)

Length of stay: In place of death 2 years 2 months 2 days. In place of residence 15 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 28, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
OCT 26, 1965 to OCT 28, 1965

I last saw her alive on OCT 26, 1965, death is stated to
have occurred on the date stated above, at 10:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) INFARCTION OF SMALL AND LARGE BOWEL(b) Due To MYOCARDIAL INFARCTION(c) Due To ARTERIOSCLEROSISOTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Howard Nathan Ginsburg, M. D.
HOWARD NATHAN GINSBURG
(Print or Type Name)

(Address) 332 BROOKLINE AVE Date OCT 28, 1965

6 Tifereth Israel Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 31, 1965

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St. Brookline

Received and filed William J. Jones NOV 2, 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Joseph Izen
(Give maiden name of wife in full)

(or) WIFE of Joseph Izen
(Husband's name in full)

12 AGE 71 Years 0 Months 0 Days If under 24 hours
Hours 0 Minutes 0

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 000-00-0000

16 BIRTHPLACE (City) Lithuania
(State or country)

17 NAME OF FATHER Hyman Herman

18 BIRTHPLACE OF FATHER (City) Lithuania
(State or country)

19 MAIDEN NAME OF MOTHER Ida (Unknown)

20 BIRTHPLACE OF MOTHER (City) Lithuania
(State or country)

21 Informant Dorothy G Kessel

60 Tamworth Hill Rd. Wakefield

(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)

Oct 29 1965

A TRUE COPY ATTEST:

William J. Lane.
City Registrar



FEB - 3 1966 AM

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Somerville

(City or town making return)

Registered No. 552 294

Middlesex

(County)

Somerville

(City or Town)

No. 12 Dearborn Rd.

 (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

 2 FULL NAME Daniel J. Grady
 (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#2

 (a) Residence. No.
(Usual place of abode)

67 Pleasant St.

 South Norwell, South
(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 October 30, 1965
 (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 Heart Disease

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 Andrew D. Guthrie

(Signed) Andrew D. Guthrie M.D.

(Address) Medford, Mass. Oct. 30-65

7 Place of death Winthrop, Mass. (City or Town)

DATE OF BURIAL Nov. 2, 1965

 8 NAME OF FUNERAL DIRECTOR Arthur J. D'Maley
 ADDRESS Winthrop, Mass.

Received and filed FEB 9 1966

(Registrar of City or Town where deceased resided)

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

 14 AGE 44 Years 11 Months 11 Days
 If under 24 hours Hours Minutes

 15 Usual Occupation: Office Manager
 (Kind of work done during most of working life)

 16 Industry or Business: Electronics
 018-16-5949

 17 Social Security No. Winthrop
 Mass.
18 BIRTHPLACE (City)
(State or country)

19 NAME OF FATHER James J. Grady

BIRTHPLACE OF FATHER (City) Boston

(State or country) Mass.

21 MAIDEN NAME Catherine Boylan

BIRTHPLACE OF MOTHER Boston

(State or country) Mass.

23 Informant Catherine Morris

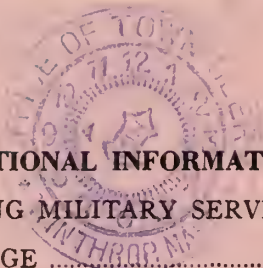
(Address) 67 Pleasant St. So. Norwell

A TRUE COPY

 ATTEST: [Signature]
 (Registrar of City or Town where death occurred)

DATE FILED 11-2-65

RECEIVED



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 2-20-42

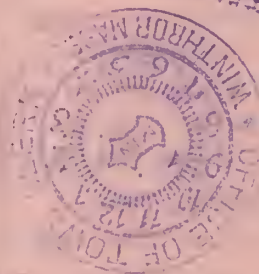
DATE OF DISCHARGE 11-20-45

RANK, RATING Radioman 1st Class

ORGANIZATION AND OUTFIT U.S. Navy

SERVICE NUMBER 705-26-72

FEB 11 1946 AM



RECEIVED

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSomerville 295
(City or Town making this return)COPY OF
CERTIFICATE OF DEATH

Registered No. 646

PLACE OF DEATH

Middlesex

(County)

Somerville

(City or Town)

No. Somerville Hospital, Crocker

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)}2 FULL NAME Sarah L. Leonard
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR, None(a) Residence, No. 573 Pleasant St.
(Usual place of abode)

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death, 3 years, 3 months, 12 days. In place of residence, 12 years, 3 months, 12 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 6, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 3, 1965, to Dec. 6, 1965
I last saw her alive on Dec. 6, 1965, death is said to
have occurred on the date stated above, at 1:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized Arteriosclerosis

INTERVAL
BETWEEN
ONSET AND
DEATH

10 years

(b) Myocarditis

5 years

(c) Hypostatic broncho
Pneumonia

2 days

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) Thomas A. Kelley M.D.
Thomas A. Kelley(Address) 52 Central St. Date 12-6-1965
Somerville, Mass.6 Holy Cross Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 9, 1965

7 NAME OF FUNERAL DIRECTOR F.E. Flaherty

ADDRESS 265 Washington St. Som., Mass.

Received and filed FEB 9 1966

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of William H. Leonard

(Husband's name in full)

12

AGE

85

Years

8

Months

22

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

House work

(Kind of work done during most working life)

14 Industry

or Business:

Own home

15 Social Security No.

030-20-8557 D

16 BIRTHPLACE (City)

(State or country)

Ireland

17 NAME OF

FATHER

James Nolan

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER

Elizabeth Bush

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21 Informant

(Address)

Records: Little Sisters of
the Poor

186 Highland Ave. Som., Mass.

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

12-8-65

19

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 668 296

PLACE OF DEATH

Suffolk
(County)

Chelsea
(City or Town)

No. Soldiers' Home Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

2 FULL NAME Henry William Dahnke
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a WWI
U. S. War Veteran,
if so specify WAR)}

(a) Residence No. 132 Court Road
(Usual place of abode)

Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 12 years, 1 months, 10 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 15, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov. 5, 1963, to Dec. 15, 1965
I last saw him live on Dec. 15, 1965 death is said to
have occurred on the date stated above, at 5:15 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Multiple sclerosis 30 yrs.

Due To (b) Arteriosclerotic heart

Due To (c) disease 10 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

(Signature) Philip T. Sorenson, M. D.

(Address) Soldiers' Home Date 12/15/65

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 18, 1965 19

7 NAME OF FUNERAL DIRECTOR Reynolds Fun. Home

ADDRESS 180 Winthrop St., Winthrop, Mass.

Received and filed JAN 14 1966 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
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced
HUSBAND of Florence Heckbert
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 73 Years 2 Months 10 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Composer-retired
(Kind of work done during most of working life)

14 Industry or Business: Boston Post

15 Social Security No. 025-09-9850

16 BIRTHPLACE (City) Chelsea, Mass.
(State or country)

17 NAME OF FATHER Christien H. Dahnke

18 BIRTHPLACE OF FATHER (City) Germany
(State or country)

19 MAIDEN NAME OF MOTHER Caroline Schmuck

20 BIRTHPLACE OF MOTHER (City) Germany
(State or country)

21 Informant Hosp. Records, Soldiers' Home

(Address) Chelsea, Mass.

A TRUE COPY

ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED Dec. 15, 1965 19

Copies of returns of deaths which occurred in your city or town in which 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.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 11/25/17

DATE OF DISCHARGE..... 9/30/21

RANK, RATING..... Seaman 2/c

ORGANIZATION AND OUTFIT..... USNRF

SERVICE NUMBER..... 130 04 53

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

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Don't make this return

COPY OF
 CERTIFICATE OF DEATH

Registered No. 297

Essex County)

Danvers (Town)

No. Danvers State Hospital-Hathorne

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

2 FULL NAME (If deceased was a divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

NO

(a) Permanent Residence. No. 76 Summit Ave. St. Winthrop Mass (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 (Day) 5 (Year) 1965

4 I HEREBY CERTIFY, That I attended deceased from Sept. 19 65 to November 5 65

I last saw him alive on November 5 65 death is said to have occurred on the date stated above, at 76 Summit Ave.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL BETWEEN ONSET AND DEATH

(a) Bronchopneumonia Days

(b) Arteriosclerotic heart dis

(c) Generalized arteriosclerosis

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Willard M. Hausman, M. D.
 Willard M. Hausman

(Address) Hathorne, Mass Date 11-5 1965

6 Workman's Circle Cemetery Melrose

DATE OF BURIAL November 7 1965

7 NAME OF FUNERAL DIRECTOR Torf Funeral Home

ADDRESS Chelsea, Mass.

Received and filed FEB 23 1966-8 1965

(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 DIVORCED UNKNOWN divorced

HUSBAND of (or) WIFE of (Husband's name in full)

12 AGE 76 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Retired

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Lithuania

17 NAME OF FATHER Joseph Cohen

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Freda

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST Tracy G. Flagg (Registrar of City or Town where death occurred)

Dir of Public Health 10-5-65

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



FEB 23 1966 AM

FORM R-301

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Agent.INSTRUCTIONS
FOR
CERTIFICATEOR TYPE
OR CAUSES
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heart failure,
etc. It means
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gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenby Med.
r's Office

1-17-65

5 1966

-65-939763

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

298

PLACE OF DEATH

I

Suffolk
(County)
Boston
(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 11431

No.

University Hospital

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Mary Chiocco (Grasso)

(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) Permanent Residence. No.

103 Banks

St.

Winthrop, Mass

(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 16 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov. 16 1965 Nov. 16 1965I last saw him alive on Nov. 16 1965 death is said to
have occurred on the date stated above, at 10:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Azotemia Azotemia

(b) Polycystic Kidneys

(c)

OTHER SIGNIFICANT CONDITIONS Hypertension, Arteriosclerotic
Heart Disease, Aorta

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Daniel E. McMarrin, M. D.

(Print or Type Name)

(Address) University Hospital Date 11/16 1965

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 20 1965

7 NAME OF FUNERAL DIRECTOR Vincent J. Mazzarella

ADDRESS 971 Saratoga St. E.B.

Received and filed NOV 22 1965

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Guy Chioccia

(Husband's name in full)

12 53 9 4
AGE Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation
(Kind of work done during most of working life)14 Industry
or Business:

15 Social Security No. 016-14-6518

16 BIRTHPLACE (City) Boston
(State or country)

17 NAME OF FATHER Michael Grasso

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Mary Macchione

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Guy Chioccia

(Address) 103 Banks 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:

William J. Kane.
City Registrar

or burial permit
rd of Health
s Agent.

CTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
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(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

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

239

Suffolk

(County)

Hyde Park

(City or Town) Hyde Park Nursing Home

No. 113 Central Ave

STANDARD

CERTIFICATE OF DEATH

Registered No. 11427

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John Henry Flynn
(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) Permanent Residence. No. 105 Grovers Ave., St. Winthrop, Mass

(City or town and State)

Length of stay: In place of death years 3 months 2 days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 18, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY. That I attended deceased from Aug 16, 1965 to Nov 18, 1965

I last saw him live on Nov 16, 1965, death is said to have occurred on the date stated above, at 1:30 pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage

(b) Cerebral arteriosclerosis

(c) General arteriosclerosis

OTHER SIGNIFICANT CONDITIONS A.S.H.D

INTERVAL BETWEEN ONSET AND DEATH Sudden

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Robert White, M. D.

(Address) 113 Central Ave, Hyde Park, Mass

(Date) Nov 18, 1965

6 Mount Hope Boston, Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 20, 1965

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed NOV 22 1965 NOV 22 1965

William J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed or divorced HUSBAND of Mary V. McDonough (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 90 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 Supreme Court

15 Social Security No.

16 BIRTHPLACE (City) East Boston (State or country) Mass

17 NAME OF FATHER Cornelius Flynn

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Margaret McDermott

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass

21 Informant Lillian Hyland

(Address) 105 Grovers Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

C17856 Kenneth W. Kane

(Signature of Agent of Board of Health or other)

NOV 19, 1965

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

FORM R-301

d for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
OR CAUSES
F DEATH

to not enter
more than one
cause for each
(a), (b) and (c)

does not mean
mode of dying,
i.e. heart failure,
etc. It means
which caused

ditions, if any,
h gave rise to
e cause (a),
ng the under-
g cause last.

conditions contrib-
to death but not
to the terminal
condition given

1966

Director
use only
ACK Ink.

5-64-938000

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

300

(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

STANDARD

CERTIFICATE OF DEATH

Registered No.

11538

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Miss HELEN BUCKLEY
(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) Permanent Residence. No. 64 SOMERSET AVE. St. WINTHROP MASS
(City or town and State)

Length of stay: In place of death 2 years 2 months 2 days. In place of residence 68 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 21 - 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY That he attended deceased from
NOV. 19 1965 to NOV. 21 1965

I last saw he alive on NOV. 21 1965, death is said to
have occurred on the date stated above, at 7:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) WIDESPREAD CARCINOMATOSISDue To ADENOCARCINOMA

Due To (b)

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 Operator

(Signature) Charles L. Cloy, M.D., M. D.

Charles L. Cloy, M.D.
(Print or Type Name)

(Address Ass't. Dir., Mass. Gen'l. Hosp. Date NOV. 21 1965)

6 HILY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 23 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS 210 WINTHROP ST WINTHROPReceived and filed NOV 24 1965 1965William J. Kane

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

FEMALE

WHITE

MARRIED
WIDOWED
DIVORCED
UNKNOWN SINGLE

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

68

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

OPERATOR

(Kind of work done during most of working life)

14 Industry

or Business

TELEPHONE SWITCH BOARD

15 Social Security No.

623-09-7828

16 BIRTHPLACE (City)

WINTHROP

(State or country)

MASS

17 NAME OF

FATHER

DANIEL J BUCKLEY

18 BIRTHPLACE OF

FATHER (City)

IRELAND

(State or country)

19 MAIDEN NAME

OF MOTHER

JULIA DONOHUE

20 BIRTHPLACE OF

MOTHER (City)

IRELAND

(State or country)

21 Informant

MRS MARY MCYENNA

(Address)

64 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:

C 17966

Benedict H. Hurd

(Signature of Agent of Board of Health or other)

NOV. 23, 1965

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

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1966

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **11556**

PLACE OF DEATH

SUFFOLK
(County)

EAST BOSTON
(City or Town)



No. **COLUMBUS NURSING HOME**

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME **THERESA VILLELLA**
(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. **163 SOMERSET AVE WINTHROP MASS**
(Usual place of abode) (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 **NOVEMBER 22, 1965**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN 26, 1956 to **NOVEMBER 22, 1965**
I last saw alive on **NOVEMBER 21, 1965**, death is said to
have occurred on the date stated above, at **7:45A.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **CARDIAC FAILURE** **1040**

(b) **CORONARY THART DISEASE** **1040**

(c) **ARTERIOSCLEROSIS GENERAL** **1040**

INTERVAL
BETWEEN
ONSET AND
DEATH

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 **NO**

(Signature) **R. N. Caplan MD**, M. D.
R. N. CAPLAN MD
(Print or Type Name)
186 PRINCETON ST EAST BOSTON **11-22-65**

6 **HOLY CROSS MALDEN**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **NOV. 24, 1965**

7 NAME OF FUNERAL DIRECTOR **DIPIETRO & VAZZA, INC**
11 HENRY ST. EAST BOSTON
ADDRESS **NOV 29 1965**

Received and filed **Nov. 29, 1965**

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

FEMALE

9 COLOR

WHITE

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **THOMAS VILLELLA**
(Husband's name in full)

12

AGE **78** 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.

HONE

16 BIRTHPLACE (City)

(State or country) **ITALY**

17 NAME OF

FATHER **PAUL MASSARO**

18 BIRTHPLACE OF

FATHER (City) (State or country) **ITALY**

19 MAIDEN NAME

OF MOTHER **NOT LEARNED**

20 BIRTHPLACE OF

MOTHER (City) (State or country) **ITALY**

21 Informant

PAUL GRAZIANO

150 CONANT ST REVERE, MASS

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Michael A. Kane
(Signature of Agent of Board of Health or other)

C1804L

(Official Designation)

NOV 23, 1965

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

FORM R-301

For burial permit
of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
the under-
lying cause

ions, if any,
gave rise to
cause (a),
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ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

302

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 11678

No.

Rosildo

2 FULL NAME

Rosildo Magnasco

(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, no
if so specify WAR)

(a) Permanent Residence. No. 39 Grover Avenue

St. Winthrop, Mass.

(City or town and State)

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 November 24, 1965
(Month) (Day) (Year)

WE HEREBY CERTIFY, That We attended deceased from
Oct. 26, 1965, to Nov. 24, 1965

We last saw him alive on Nov. 24, 1965 death is said to
have occurred on the date stated above, at 2:00PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac arrest seconds

Due To Cystitis with hematuria weeks

(b)
(c)

OTHER SIGNIFICANT CONDITIONS Anteriosclerotic cardio-vascular disease

years

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

(Signature) Leon R. Lezer, M.D.
LEON R. LEZER, M.D.
(Print or Type Name)

BOSTON CITY HOSPITAL Date 11/24/65

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 29 1965

7 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed William J. Scane 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Florence DelTergo
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

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 *****

15 Social Security No. unknown

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Nicola Magnasco

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Maria Pasquale

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

James Magnasco (son)

21 Informant (Address) 1057 Saratoga St., East Boston, Mass

I HEREBY CERTIFY that 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)

1966

65-939763

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

OUT OF TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Boston 303
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 11816

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL
Curtis

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Wilbur C. Bryant
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WARI... NO.

(a) Permanent Residence. No. 67 Cottage Avenue St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death... years... months... 1 days. In place of residence... 50 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 26 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
November 25, 19 65 to November 26, 19 65

last saw him live on November 26, 19 65 death is said to

have occurred on the date stated above, at 3:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Peritonitis 36 Hrs

Due To (b) Perforation of Jejunum 36 Hrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS Coronary Heart Disease 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

(Signature) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Nov. 26 19 65

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 29, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed DEC 1 1965

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the words) Married

11 If married, widowed, or divorced HUSBAND of Hilda Elizabeth Lauretzen (or) WIFE of (Give maiden name of wife in full) (Husband's name in full)

12 AGE 76 Years 1 Months 13 Days If under 24 hours Hours Minutes

13 Usual Occupation Railroad Engineer (Kind of work done during most of working life)

14 Industry or Business New York Central R.R.

15 Social Security No. none

16 BIRTHPLACE (City) Paxton (State or country) Massachusetts

17 NAME OF FATHER Edward Bryant

18 BIRTHPLACE OF FATHER (City) Paxton (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Alice Stoddard

20 BIRTHPLACE OF MOTHER (City) Palmer (State or country) Massachusetts

21 Informant Edward C. Bryant

(Address) Depot Road, Boxford, 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:

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

NORFOLK

(County)

BROOKLINE

(City or Town)



COPY OF
CERTIFICATE OF DEATH

BROOKLINE
(City or Town making this return)

Registered No. 908 304

No. Brooks Hospital-227 Summit Avenue

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

Charles

Hablitz

2 FULL 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) Permanent Residence. No.

76 Banks

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months 34.....days. In place of residence 8.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 12, 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
August 19 65 December 12, 19 65
I last saw him alive on December 12, 19 65, death is said to
have occurred on the date stated above, at 11:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
-?-

(a) Due To Metastatic carcinoma of
(b) Stomach

(c) Due To

OTHER
SIGNIFICANT
CONDITIONS

INTERVAL
BETWEEN
ONSET AND
DEATH

Was autopsy performed? No
What test confirmed diagnosis? XRay, surgery.

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) M. Taeb, M.D. / Dr. Olierfield, M. D.

(Address) Lahey Clinic Dec. 12, 65

6 Winthrop Cemetery-Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 15, 19 65

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
117 Winthrop Street
Winthrop, Massachusetts

ADDRESS

Received and filed MAR 4 1966 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 Married
DIVORCED
UNKNOWN

11 If married, widowed, or divorced,
HUSBAND of Margaret DeMarco
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 63 Years - Months - Days If under 24 hours
Hours - Minutes

13 Usual Occupation: Shipfitter
(Kind of work done during most of working life)

14 Industry or Business: Navy Yard

15 Social Security No. 030-07-5733

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER Charles Hablitz

18 BIRTHPLACE OF FATHER (City) Massachusetts
(State or country)

19 MAIDEN NAME OF MOTHER Mary Doherty

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Massachusetts

21 Informant Margaret Hablitz
76 Banks Street
(Address) Winthrop, Massachusetts

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED December 14, 19 65

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



MAR - 4 1966 AM

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk
(County)Boston
(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 12187

No. 638 TREMONT

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

Blackburn

PHYSICIAN — IMPORTANT

2 FULL NAME

HOWARD JORDAN

(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.2

(a) Permanent Residence. No.

638 TREMONT

St. BOSTON, MASS.

(City or town and State)

Length of stay: In place of death 4 years.....months.....days. In place of residence 4 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 7 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19....., to 19....., 19.....I last saw him alive on 19....., death is said to
have occurred on the date stated above, atm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) LAENNAE'S CIRRHOSIS

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? HISTORY

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Wm. G. Duserick, M. D.

BOSTON HEALTH DEPT. (Print or Type Name) 12-7 65
(Address) Date 19.....6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 9, 1965 19.....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed DEC 13 1965 19.....

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED single
WIDOWED
DIVORCED
UNKNOWNmale white
11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 47 Years 9 Months 21 Days
If under 24 hours
..... Hours..... Minutes13 Usual Occupation retired machinest
(Kind of work done during most of working life)

14 Industry or Business: Bethlehem Steell

15 Social Security No. none

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

17 NAME OF FATHER Albert Edward Jordan

18 BIRTHPLACE OF FATHER (City) Portland
(State or country) Maine

19 MAIDEN NAME OF MOTHER Alice Shields

20 BIRTHPLACE OF MOTHER (City) Gloucester
(State or country) Massachusetts

21 Informant Mrs. Anna O'Donnell

(Address) 27 Floyd St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
has been filed with me BEFORE the burial or transit permit was issued:Dugan Leonard E 18646
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



MAR 11 1966 AM

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

306

(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)

New England Medical Center Hospitals

No.

STANDARD

CERTIFICATE OF DEATH

Registered No.

12179

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marshall Nelson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, WW 11
if so specify WAR)

1 Shore Drive

Winthrop, Massachusetts

(a) Permanent Residence. No.

St.

(City or town and State)

Length of stay: In place of death, years, months, 28 days. In place of residence, 55 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 8 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
November 10, 1965 to December 8 1965
I last saw him live on December 8 1965 death is said to
have occurred on the date stated above, at 7:55a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Head of Pancreas

Due To Upper Gastro-Intestinal Hemorrhage

(b) Due To

(c) OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? Yes
What test confirmed diagnosis? Surgery, Autopsy5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Robert K. Asensio, M. D.

Robert K. Asensio

(Print or Type Name)

(Address) New England Center Hospitals Date Dec 8 1965

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 11 1965 1965

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed DEC 13 1965 19

V. J. Kane (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Florence C. De Costa Nelson
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 55 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Maintenance Supervisor
(Kind of work done during most of working life)

14 Industry or Business: Office Bldg.

15 Social Security No. 029 16 0254

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

17 NAME OF FATHER William Nelson

18 BIRTHPLACE OF FATHER (City) Winthrop
(State or country) Mass

19 MAIDEN NAME OF MOTHER Mae D. LaCotte Nelson

20 BIRTHPLACE OF MOTHER (City) Boston,
(State or country) Mass.21 Informant Florence C Nelson
(Address) 1 Shore Drive Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
has been 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)filed for burial permit
by Board of Health
or Its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEPRINT OR TYPE
NAME OR CAUSES
OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)this does not mean
mode of dying,
as heart failure,
pneumonia, etc. It means
disease, or compli-
cations which caused
death.conditions, if any,
which gave rise to
above cause (a),
listing the under-
lying cause last.Conditions contrib-
uting to death but not
related to the terminal
disease condition given
(a).

1 1966

TRUE COPY ATTEST:

William J. Kane

City Registrar



MAR 11 1966 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

12226

Registered No.

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

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 Nicholas Gallese
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR1 NO(a) Permanent Residence. No. 46 SAGAMORE St. Winthrop, Massachusetts
(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 December 9, 1965
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
November 24, 1965, to December 9, 1965.I last saw him alive on December 9, 1965 death is said to
have occurred on the date stated above, at 1:40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intracranial Hemorrhage

Due To Traumatic Origin

(b) (Fall in Nursing Home)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Carcinoma of the Aesophagus

Was autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles L. Clay, M.D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) Ass'n. Dir., Mass. Gen'l. Hosp. Date Dec. 9, 1965

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC. 13, 1965

7 NAME OF FUNERAL DIRECTOR DIPIETRO & VAZZA

11 HENRY ST, EAST BOSTON
ADDRESSReceived and filed DEC. 4, 1965
William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN11 If married, widowed, or divorced
HUSBAND of GRACE RUSCI
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 81 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation LABORER (RETIRED)
(Kind of work done during most of working life)

14 Industry or Business ROAD CONST.

15 Social Security No. 033-10-9434

16 BIRTHPLACE (City) ITALY
(State or country)

17 NAME OF FATHER NOT LEARNED

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 YOLA CAPANO
65 SAGAMORE AVE, WINTROP, 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

A TRUE COPY ATTEST:

FORM R-301

d for burial permit
Board of Health
its Agent.STRUCTIONS
FOR
AL CERTIFICATERIT OR TYPE
E OR CAUSES
F DEATHo not enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
is heart failure,
a, etc. It means
e, or compli-
which causedditions, if any,
h gave rise to
e cause (a),
ing the under-
t cause last.onditions contrib-
to death but not
to the terminal
condition given

Declined by Medical Examiner

11 1966

al Director
se use only
LACK Ink.

5-64-938000

A TRUE COPY ATTEST:

William J. [Signature]



MAR 11 1966 AM

The Commonwealth of Massachusetts

308

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Boston
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 12207



Suffolk
(County)

Boston
(City or Town)

PLACE OF DEATH

No. Veterans Administration Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

Francis R. BOUDREAU

PHYSICIAN — IMPORTANT

2 FULL NAME. (If deceased is a married, widowed or divorced woman, give also maiden name.)
Francis R. BOUDREAU (Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Permanent Residence. No. 77 Somerset Avenue Winthrop Arms Hotel, Groves Ave, Winthrop, Mass.
St. Winthrop (City or town and State)

Length of stay: In place of death. 1 years. months. days. In place of residence 21 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 10 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1965, to December 10, 1965

death is said to have occurred on the date stated above, at 6:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction.

INTERVAL BETWEEN ONSET AND DEATH
3-Days

(b) Due To Arteriosclerotic heart dis.

Years

(c) Due To

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

(Signature) Leon Menzer, M.D.

Leon Menzer, M.D.

(Address) VAH Boston, Mass. Dec. 11, 1965

6 Winthrop cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 13, 1965

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop, Mass.

Received and filed DEC 14 1965

William J. Leane

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Flora Gladys Stober (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 77 Years 1 Months 15 Days If under 24 hours Hours Minutes

13 Usual Occupation Tug Boat Captain (Kind of work done during most of working life)

14 Industry or Business Ross Tow Boat Co.

15 Social Security No. 024 10 6373

16 BIRTHPLACE (City) Canada (State or country)

17 NAME OF FATHER Thomas Boudreau

18 BIRTHPLACE OF FATHER (City) Canada (State or country)

19 MAIDEN NAME OF MOTHER Carolyn Boudreau

20 BIRTHPLACE OF MOTHER (City) Canada (State or country)

Mrs. Francis R. Boudreau Winthrop V. A. Hospital Records

21 Informant 150 So. 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) C18761 12-12-65 (Official Designation) (Date of Issue of Permit)

FORM R-301

for burial permit
Board of Health
Site Agent.

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

OR TYPE
OR CAUSES
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-
cation which caused

ditions, if any,
which gave rise to
the cause (a),
the under-
lying cause last.

ditions contrib-
uting to death but not
to the terminal
condition given

1966

65-939763

A TRUE COPY ATTEST:

William J. K...
City Registrar



MAR 11 1966 AM

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

12939

Registered No.

Suffolk

(County)

Boston

(City or Town)

STANDARD
CERTIFICATE OF DEATH

No. New England Center Hospital

(If death occurred in a hospital or institution,
State give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

2 FULL NAME Minnie Coffin

(If deceased is a married, widowed or divorced woman, give also maiden name.)

Bay View Nursing Home

(a) Permanent Residence. No 26 Sturgis St. 30 James Ave St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months 11 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 28, 1965

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
December 14, 1965, to December 28, 1965I last saw her alive on December 28, 1965, death is said to
have occurred on the date stated above, at 12:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease, congestive
heart failure.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS1. Necrotic varicose leg ulcer
2. ? Salmonella carrier since 1951

Was autopsy performed? Yes

What test confirmed diagnosis? EKG, Chest X-ray

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signature) Gerald S. Harris, M. D.

(Print or Type Name)

(Address) New Eng. Center Date Dec 28, 1965

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 30, 1965

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed JAN 3, 1966

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

George W. Coffin

(Husband's name in full)

12

AGE 88

Years

4 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:

Own home

15 Social Security No.

None

16 BIRTHPLACE (City)

(State or country)

Moncton

New Brunswick

17 NAME OF

FATHER

John Boyd

18 BIRTHPLACE OF

FATHER (City)

Moncton

(State or country)

New Brunswick

19 MAIDEN NAME

OF MOTHER

Margaret Tait

20 BIRTHPLACE OF

MOTHER (City)

Moncton

(State or country)

New Brunswick

21 Informant Lucille Harding

(Address) Ash Brook Rd. Exeter, N H

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)

Dec 25, 1965

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Wm. S. Lee.
Clerk of the Court



MAR 11 1966 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 12928

No. BETH ISRAEL HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME BABY BOY CUNNINGHAM

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR.) 1

(a) Permanent Residence, No. 62 ALMONT ST

(Usual place of abode)

St. WINTHROP

(City or town and State)

34 HOURS

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 28 1965
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 27 1965, to Dec 28 1965

I last saw him alive on 12-28 1965, death is said to have occurred on the date stated above, at 5:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) HYALINE MEMBRANE DISEASE, LUNGS

INTERVAL BETWEEN ONSET AND DEATH HRS.

(b) Due To

(c) Due To

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

(Signature) M. L. REINER, M. D.

(Print or Type Name)

(Address) BETH ISRAEL HOSP Date 12-28 1965

6 WINTHROP Cem. WINTHROP, MASS.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 29 Dec 1965

7 NAME OF FUNERAL DIRECTOR Sweeney Funeral Home

ADDRESS 350 Broadway, Everett

Received and filed JAN 3 1966

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

Years

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)

(State or country)

17 NAME OF

FATHER

18 BIRTHPLACE OF

FATHER (City)

(State or country)

19 MAIDEN NAME

OF MOTHER

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

21 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)

A TRUE COPY ATTEST:

R-301

Burial permit

ent.

INS

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TYPE
CAUSES

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terminal

in given

348

1966

A TRUE COPY ATTEST:

William Lee
Clerk of the Court



MAR 11 1966 AM

