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Commonwealth of Massachusetts

CERTIFICATE OF BIRTH

FROM THE RECORDS OF BIRTHS IN THE
TOWN OF WINTHROP, MASSACHUSETTS

Date of Birth: July 11, 1956

Full Name of Child: Edward Joseph Jones

Sex, Color and if Twin: M, W, ----

Place of Birth: Winthrop Community Hospital

Name of Father: Edmund Jones, Jr.

Maiden Name of Mother: Eleanor Mary Gallagher

Residence of Parents: 114 Nichols Street, Wilmington, MA

Occupation of Father: Warehouse Man

Occupation of Mother: Homemaker

Birthplace of Father: Boston, MA

Birthplace of Mother: Boston, MA

Date of Record: July 13, 1956

Registration No.: 530

I, the undersigned, hereby certify that I am clerk of the Town of Winthrop; that as such I have custody of the records of births required by law to be kept in my office.

And I do hereby certify that the forgoing is a true copy from said records.

Witness my hand and seal of said Town of Winthrop on this 5th day of May 2014

Carla Vitale, Town Clerk

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.

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No.

Winthrop Hospital

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

PHYSICIAN — IMPORTANT

2 FULL NAME Olivia Panaro (Sgamorra)
(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. 963 Saratoga St. East Boston
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....10days. In place of residence.....34years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. 1 - 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov. 1966, to Dec 31, 1966
I last saw him alive on Dec 31, 1966, death is said to
have occurred on the date stated above, at 10:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypostatic Pneumonia

Due To
(b) Cerebral thrombosis

Due To
(c) Arteriosclerotic hypertensive disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical

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

(Signed) Charles Meloni, M. D.
CHARLES MELONI M. D.
(Print or Type Name)
(Address) 45 Baywater St. Boston Date Jan 1 1967

6 St. Michael's Roslindele
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 4 1967

7 NAME OF FUNERAL DIRECTOR Vincent J. Iazzarella
ADDRESS 971 Saratoga St. E.E.

Received and filed JAN 3 1967 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐

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

12 DATE OF BIRTH 7/30/1879
13 AGE 87 Years 5 Months 2 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.

17 BIRTHPLACE (City) Italy
(State or country)

18 NAME OF FATHER P.P.E.L. SGAMORRA

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

20 MAIDEN NAME OF MOTHER C.N.F.L.

21 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

22 Informant Olga Panaro
(Address) 963 Saratoga St. E.E.

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

Richard Griffin (MCK)
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) 1/3/67 (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

INSTRUCTIONS FOR LOCAL CERTIFICATE

In giving
USE OF DEATH

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

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

nditions, if any,
ich gave rise to
ove cause (a),
iting the under-
ing cause last.

Conditions contrib-
g to death but not
ed to the terminal
se condition given
1).

Note:- Chapter 137,
cts of 1954 requires
hysicians to print or
pe the cause or
auses of death on
eath certificates, and
hapter 48, Acts of
1959, requires Physi-
cians to print or type
ame under signature.

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

RULES OF PRACTICE

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

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

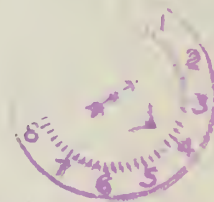
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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

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

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

JAN - 2 '67 PM



CLERK OF THE TOWN CLERK
 WINTHROP, MASS.

FORM R-301

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 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).

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
(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 2

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

2 FULL NAME ABRAHAM BREITMAN
(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. 208 GROVERS AVE., St. WINTHROP, MASS.
(City or town and State)

Length of stay: In place of death, 2 years, months, days. In place of residence 27 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 3, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN 1956 to JAN 3, 1967

I last saw him alive on JAN 2, 1967, death is said to
have occurred on the date stated above, at 5:50 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular Occlusion 1 month

(b) Due To Cerebral arteriosclerosis 8 yrs

(c) Due To

OTHER SIGNIFICANT CONDITIONS Left Hemiplegia 8 yrs
ARTERIOSCLEROTIC Heart Disease 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.
(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date Jan. 3, 1967
Maple Hill Peabody, Mass.

6 Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 4, 1967

7 NAME OF FUNERAL DIRECTOR Morris W. Brezniak
470 Harvard St., Brookline
ADDRESS

Received and filed JAN 3 1967
John A. Clark (Registrar)

A TRUE COPY ATTEST:

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 Rebecca Rubin
(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 Manufacturer
(Kind of work done during most of working life)

14 Industry or Business: Shoes

15 Social Security No. 01-1-1-029-05-5773

16 BIRTHPLACE (City) c/n/b/l/ Russia
(State or country)

17 NAME OF FATHER Louis Breitman

18 BIRTHPLACE OF FATHER (City) c/n/b/l/ Russia
(State or country)

19 MAIDEN NAME OF MOTHER Esther (unknown)

20 BIRTHPLACE OF MOTHER (City) c/n/b/l/ Russia
(State or country)

21 Informant Mr. David Breitman
270 Beacon St., Boston
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Richard H. Griffin (Signature of Agent of Board of Health or other)
Director of Public Health 1/3/67
(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.

JAN - 3 '67 PM



WINTER MASS

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

3

STANDARD CERTIFICATE OF DEATH

Registered No.

FORM R-301

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



No. Viking Nursing Home
142 Pleasant St.

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

PHYSICIAN — IMPORTANT

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

2 FULL NAME ALICE S. KIRKORIAN (Sargent)
(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. 83 Atlantic Ave.
(Usual place of abode)

St. Revere
(City or town and State)

Length of stay: In place of death 4 years 20 months 20 days. In place of residence 20 years 20 months 20 days.

NT OR TYPE
E OR CAUSES
F DEATH

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

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

ditions, if any,
ich gave rise to
ve cause (a),
ling the under-
g cause last.

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 3 - 67
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
JAN 10 1962 to JAN 3 1967
I last saw him alive on JAN 3 1967 death is said to
have occurred on the date stated above, at 7:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION 5 days

Due To (b) ARTERIO SCLEROTIC HEART DISEASE 5 yr

Due To (c) BRONCHOPNEUMONITIS 10 days

OTHER SIGNIFICANT CONDITIONS CARDIAC FAILURE 1 day

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) Andrew Capino, M. D.

ANDREW CAPINO
(Print or Type Name)

(Address) 603 Broadway Revere Date JAN 4 1967

6 Plymouth Cemetery Plymouth N.H.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 6, 1967

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike

ADDRESS 305 Beach St. Revere

Received and filed JAN 6 1967

John A. Sark
(Registrar)

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 Harry Kirkorian (Give maiden name of wife in full)
(or) WIFE of Harry Kirkorian (Husband's name in full)

12 AGE 79 Years 3 Months 23 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. 024-14-7428B

16 BIRTHPLACE (City) Franklin (State or country) N. H.

17 NAME OF FATHER Herman L. Sargent

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

19 MAIDEN NAME OF MOTHER Unable to Learn

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

21 Informant Harry Kirkorian

(Address) 83 Atlantic Ave. Revere

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

Richard Griffin
(Signature of Agent of Board of Health or other)

Superintendent of Health
(Official Designation)

1/6/67
(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.

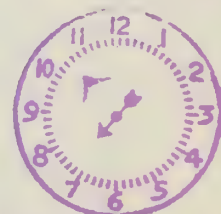
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

JUN -6 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

PLACE OF DEATH

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

Registered No. 4

No. 26 ALMONT ST. - WINTHROP (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bessie Bensusan (SHEINKER) (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. 26 ALMONT St. WINTHROP, MASS. (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN. 4 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from JAN. 50 to JAN. 4, 1967. I last saw her alive on Jan 2, 1967, death is said to have occurred on the date stated above, at 10:05 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive and arterio-sclerotic Heart Disease 20yrs.

Due To (b) ...

Due To (c) ...

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus 15yrs. Cerebral Arteriosclerosis 8yrs.

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.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 1/4/1967

6 Roxbury Mutual Society WOBURN (City or Town)

DATE OF BURIAL JANUARY 5 1967

7 NAME OF FUNERAL DIRECTOR SOLOMON FUNERAL HOME

ADDRESS 420 HARVARD ST. - BROOKLINE

Received and filed JAN 5 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

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)

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

12 AGE 71 Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business A + Home

15 Social Security No. NONE

16 BIRTHPLACE (City) CHASEA, MASS. (State or country)

17 NAME OF FATHER DAVID SHEINKER

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

19 MAIDEN NAME OF MOTHER ROSE FINE

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

21 Informant MYER BENSUSAN

(Address) 26 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:

Richard Griffin (B)

(Signature of Agent of Board of Health or other)

Dir. of Public Health 7/5/67

(Official Designation) (Date of Issue of Permit)

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 complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.

Conditions contributing to death but not related to the terminal disease condition given in (a).

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 - 5 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

Suffolk

(County)

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

WINTHROP

(City or Town making this return)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No.

5

No. 17 Hawthorne Ave

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

PHYSICIAN — IMPORTANT

2 FULL NAME Frank J. Downs

(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. 17 Hawthorne Ave.

St.

(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 JAN. 4, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw him alive on 19, death is said to
have occurred on the date stated above, at 11:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) 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.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date Jan. 4, 1967

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

DATE OF BURIAL January 7, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JAN 6 1967

A TRUE COPY ATTEST:

(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 Agnes LaPreniere
(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 Minutes13 Usual Occupation Chauffeur
(Kind of work done during most of working life)

14 Industry or Business: Cleansing

15 Social Security No. 024-14-7977

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

17 NAME OF FATHER Thomas J. Downs

18 BIRTHPLACE OF FATHER (City) Tarbay
(State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Ellen Keary

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

21 Informant Carol Panetta

(Address) 17 Hawthorne Ave

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Richard Griffin Jr.
(Signature of Agent of Board of Health or other)Dir. of Public Health Jan 6 1967
(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.

JAN - 6 '67 PM



OFFICE OF THE TOWN CLERK

WINTHROP, MASS

The Commonwealth of Massachusetts

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

Winthrop
(City or Town making this return)

FORM R-301

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 6

ed for burial permit
Board of Health
r its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

No. Bay View Nursing Home (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
2 FULL NAME Salena Gertrude Belcher (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 34 Pleasant Street St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 6 months days. In place of residence 50 years months days.

IT OR TYPE
OR CAUSES
F DEATH

o 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 caused

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

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 7 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Jan 1935 to JAN 7 1967
I last saw her live on JAN 7 1967, death is said to have occurred on the date stated above, at 10³⁰ am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

Due To (b) HYPERTENSION

Due To (c) CHRONIC ARTHRITIS

OTHER SIGNIFICANT CONDITIONS SENILITY

Was autopsy performed? NO

What test confirmed diagnosis?

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

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

(Print or Type Name) LOUIS F. SALERNO

(Address) 78 Pleasant St. Winthrop Date 1/7/67

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

DATE OF BURIAL January 10, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed JAN 10 1967

(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 82 Years 11 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

15 Social Security No. 012-16-1939-T

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

17 NAME OF FATHER Warren Emerson Belcher

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

19 MAIDEN NAME OF MOTHER Elisabeth Davis

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

21 Informant E. Foster Belcher

(Address) 230 Lincoln 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) 1/8/67

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.

10 67 PM



OFFICE OF THE TOWN CL
 WINTHROP, MASS.

d for burial permit
Board of Health
its Agent.

STRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
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),
g the under-
cause last.

ditions 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)

STANDARD
CERTIFICATE OF DEATH

Registered No.

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

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH FALCO
(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. 123 QUINCY AVE St. WINTHROP
(Usual place of abode) (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 8 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Oct 7, 1966, to January 8, 1967
I last saw him alive on January 8, 1967, death is said to
have occurred on the date stated above, at 1:01 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Infarction(b) Coronary Artery(c) DiseaseOTHER SIGNIFICANT CONDITIONS Peptic ulcer

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 GREGGIE, M. D.

(Print or Type Name)

(Address) 194 Washington St. Date 1-10 1967

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

DATE OF BURIAL JAN 11 19677 NAME OF FUNERAL DIRECTOR MAURICE W KIRBYADDRESS WINTHROPReceived and filed JAN 10 1967 1967

John A. Clark
(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 PAULINE M. MARINO
(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 UPHOLSTERER
(Kind of work done during most of working life)

14 Industry or Business WPH FURNITURE

15 Social Security No. 021-09-1106

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

17 NAME OF FATHER BALDAROSSO FALCO

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

19 MAIDEN NAME OF MOTHER ANNA CARPANO

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

21 Informant MRS PAULINE FALCO

(Address) 123 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:

Richard Griffin (M.D.)
(Signature of Agent of Board of Health or other)
Director of Public Health (Official Designation) 1/10/67 (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.

JUN 10 1967 PM



LERK

FORM R-301

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 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).

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.

8

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



No.

110 Bayview Ave

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

2 FULL NAME

Bryana Marie McGough

(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.

110 Bayview Ave

St.

(City or town and State)

Length of stay: In place of death 0 years 3 months 2 days. In place of residence 0 years 3 months 2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH1/14/67
(Month)8
(Day)1967
(Year)

4 I HEREBY CERTIFY, That I attended deceased from

10/13

1966

to 1/8

1967

I last saw him alive on 1/8/67, death is said to
have occurred on the date stated above, at 8:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CONGENITAL HEART DISEASE

Due To

MONGOLISM

(b)

Due To

(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? No

If so, specify

(Signature)

M. Traubstein Jr. M.D.
M. TRAUBSTEIN JR. M.D.
(Print or Type Name)

(Address)

73 BARTLET ST.

Date JAN 8, 1967

6 Place of Burial or Cremation

Mt Pleasant Cemetery Arlington

(City or Town)

DATE OF BURIAL

January 9, 1967

7 NAME OF
FUNERAL DIRECTOR

John E. McAvoy

ADDRESS

223 Mass. Ave. Arlington

Received and filed

JAN 9 1967

19

A TRUE COPY ATTEST:

(Registrar)

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 0 Years 3 Months 2 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation

(Kind of work done during most of working life)

14 Industry

or Business

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Winthrop Mass.

17 NAME OF

FATHER

Thomas J. McGough

18 BIRTHPLACE OF

FATHER (City)

Arlington Mass

(State or country)

19 MAIDEN NAME

OF MOTHER

June A. De Courcy

20 BIRTHPLACE OF

MOTHER (City)

Boston Mass.

(State or country)

21 Informant

Thomas J. McGough

(Address)

110 Bayview Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Richard Griffin Jr.
(Signature of Agent of Board of Health or other)Director of Public Health
(Official Designation)1/9/67
(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.

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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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JUN - 9 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

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. 9

No. Viking Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Minna Davis Feldman
(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. 80 Sagamore Avenue St. Winthrop, Mass.

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 9, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
12-3-65, 1965, to 1-9-67, 1967.
I last saw alive on 1-9-67, 1967, death is said to
have occurred on the date stated above, at 6:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) UREMIA + CARDIAC DECOMPENSATION
(b) ARTERIO SCLEROSIS

Due To (c) 5 MO.

OTHER SIGNIFICANT CONDITIONS MYXED EDEMA FRACTURE 2ND LUMBAR VERTEBRA 1 MO.

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. N. Caplan, M. D.
A. N. CAPLAN, M.D.
(Print or Type Name)
(Address) 186 PRINCETON ST. E. B. Date 1-9-676 Creation, Woodlawn Crematory, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 12, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JAN 11 1967

A TRUE COPY ATTEST

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED widow
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Abraham Feldman
(Husband's name in full)12 AGE 69 years 10 months 1 days If under 24 hours
Hours Minutes13 Usual Occupation housekeeper
(Kind of work done during most of working life)

14 Industry or Business private homes

15 Social Security No. 024-14-7958

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

17 NAME OF FATHER Morris Davis

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

19 MAIDEN NAME OF MOTHER Jennie Rose Nathan

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

21 Informant Mary Weisberg

(Address) 80 Sagamore Ave. Winthrop

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

Richard Griffin (Signature of Agent of Board of Health or other)

Dir of Public Health Jan 11, 1967
(Official Designation) (Date of Issue of Permit)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).

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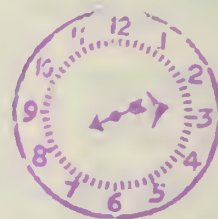
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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11 11 '67 PM



WINTHROP, MASS.

Suffolk

(County)

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

Winthrop

(City or Town making this return)

1

PLACE OF DEATH

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 10

Winthrop Community Hospital

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

Concetta (Mainero)

Mrs. Notta Santarpio

2 FULL 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. 120 Bremen St. East Boston, 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 January 12 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from August 10, 1966, to Jan 12, 1967.
I last saw him alive on Jan 12, 1967, death is said to have occurred on the date stated above, at 17 in.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Liver e Metastasis
Carcinoma of Liver e Metastasis

Due To (b)

Due To (c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? *no*
What test confirmed diagnosis? *Biopsy - Laboratory Memorial Hospital*5 Was disease or injury in any way related to occupation of deceased? *no*
If so, specify(Signature) *Peter J. Ferrino* M. D.(Address) *21 BENNINGTON ST. E. Boston* Date *1-12 1967*6 *Holy Cross Cemetery Malden*
Place of Burial or Cremation (City or Town)DATE OF BURIAL *January 14 1967*7 NAME OF FUNERAL DIRECTOR *Vincent R. Rapino*ADDRESS *9 Chelsea St., East Boston, Mass.*Received and filed *JAN 16 1967* 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *female* 9 COLOR *white* 10 SINGLE (write the word) *MARRIED*
MARRIED
WIDOWED
DIVORCED *divorced*
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of *Joseph Santarpio*
(Husband's name in full)12 AGE *54* 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) *Boston, Mass.*
(State or country)17 NAME OF FATHER *Frank Mainero*18 BIRTHPLACE OF FATHER (City) *Italy*
(State or country)19 MAIDEN NAME OF MOTHER *Frances Goduti*20 BIRTHPLACE OF MOTHER (City) *Italy*
(State or country)21 Informant *Frank Santarpio (son)*(Address) *120 Bremen 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:

Richard Griffiths
(Signature of Agent of Board of Health or other)Director of Public Health *Jan 13, 1967*
(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
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).

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.

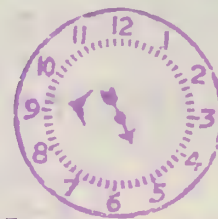
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

JUN 16 67 AM



OFFICE OF THE TOWN CLERK
 WINTHROP, MASS

FORM R-301

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. 174 Cottage Park Road

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

PHYSICIAN — IMPORTANT

2 FULL NAME Mary J. Giorgio (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) no

(a) Permanent Residence. No. 174 Cottage Park Rd. St. Winthrop

(City or town and State)

Length of stay: In place of death 26 years months days. In place of residence 26 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20, 1967
(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

Due To (c) causes.

OTHER
SIGNIFICANT
CONDITIONSWinthrop 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.

(Print or Type Name) Charles Liberman

Winthrop Board of Health 1/21/67
(Address) (Date)6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 23, 1967

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

Received and filed JAN 23 1967 John A. Gark 19

A TRUE COPY ATTEST:

(Registrar)

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 Angelo Giorgio
(Husband's name in full)12 AGE 57 Years 4 Months Days If under 24 hours
Hours Minutes13 Usual Occupation housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.

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

17 NAME OF FATHER Lorenzo Marotta

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

19 MAIDEN NAME OF MOTHER Maria Vitello

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Angelo Giorgio
174 Cottage Park 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:Richard Griffin 19
(Signature of Agent of Board of Health or other)Dir. of Public Health 1/21/67
(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.

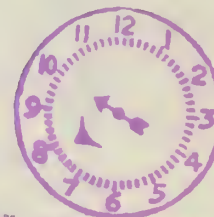
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

JAN 23 '67 PM



OFFICE OF THE TOWN CLERK
BOSTON, MASS

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

Registered No. 12

STANDARD
CERTIFICATE OF DEATH1 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 MRS. ELIZABETH BRADFORD (CAMERON)
(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 TAFTS AVENUE St. WINTHROP, MASS.
(City or town and State)

Length of stay: In place of death years months 4 days. In place of residence 70 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 21, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
DEC 23, 1964, to JAN 21, 1967
I last saw him alive on JAN 20, 1967, death is said to
have occurred on the date stated above, at 533 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR HEMORRHAGE
LEFT HEMISPHERE

(b) Due To ARTERIO-SCLEROTIC & HYPERTENSIVE 54RS

(c) Due To HEART DIS
CONGESTIVE FAILURE 2WKS

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 3YRS

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. Date 1/21/1967
WINTHROP, MASS.6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 25 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP

Received and filed JAN 23 1967 19

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 (Give maiden name of wife in full)

(or) WIFE of FREDERICK BRADFORD
(Husband's name in full)12 AGE 84 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation RESTAURANT PROP.
(Kind of work done during most of working life)

14 Industry or Business RESTAURANT

15 Social Security No.

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

17 NAME OF FATHER CHRISTOPHER KAMMERER

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

19 MAIDEN NAME OF MOTHER MARY BAKER

20 BIRTHPLACE OF MOTHER (City) BOSTON, MASS.
(State or country)

21 Informant MRS BARBARA BROOKS

(Address) 65 DEACONESS RD BOSTON MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Richard Griffin (P)
Signature of Agent of Board of Health or other
Dir of Public Health 1/23/67
(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
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).

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 23 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

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. 13

 No. Cliff House Nursing Home, 170 Cliff Ave. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME George A Lawson

(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. 106 Bellevue Ave.
 (Usual place of abode)
St. Winthrop, Mass.

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH JAN 23 1967
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from AUG 28 1961 to JAN 23 1967

 I last saw him alive on JAN 23 1967 death is said to have occurred on the date stated above, at 6:15 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCCLUSION 1/2 HR(b) ARTERIO-SCLEROTIC HEART DISEASE 5 YRS(c) WITH CONGESTIVE FAILURE
 INTERVAL
 BETWEEN
 ONSET AND
 DEATH
OTHER SIGNIFICANT CONDITIONS NONEWas 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) Myron N. King, M. D.
MYRON N. KING M.D.

 (Address) 22 Pleasant St. Date 1/23 1967
WINTHROP MASS

 6 Woodlawn Cem. Everett
 Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 26, 19 677 NAME OF FUNERAL DIRECTOR Maurice W KirbyADDRESS WinthropReceived and filed JAN 26 1967 19 67
John A. Clark
 (Registrar)

A TRUE COPY ATTEST:

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 Ella P Kelley
 (Give maiden name of wife in full)

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

 12 AGE 79 Years 79 Months 0 Days If under 24 hours 0 Hours 0 Minutes

 13 Usual Occupation Carpenter
 (Kind of work done during most of working life)
14 Industry or Business Bldg. Construction15 Social Security No. 010-07-387916 BIRTHPLACE (City) St. John's
 (State or country) N.B.
17 NAME OF FATHER Robert E Lawson
 18 BIRTHPLACE OF FATHER (City) St. John's
 (State or country) N.B.
19 MAIDEN NAME OF MOTHER Georgiana Gray
 20 BIRTHPLACE OF MOTHER (City) St. John's
 (State or country) N.B.

 21 Informant Mrs Ethel O'Connell
 (Address) 106 Bellevue Ave. Winthrop, Mass
Bellevue

 I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Richard Sullivan
 (Signature of Agent of Board of Health or other)
Dir of Public Health Jan 26 1967
 (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.

FORM R-301

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. 141

PLACE OF DEATH

Suffolk

(County)

WINTHROP

(City or Town)

No. 17 Cutler St

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

PHYSICIAN — IMPORTANT

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE2 FULL NAME SOLOMON SHAPIRO
(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. 17 CUTLER St. WINTHROP
(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 Jan 30 1967
(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 11:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
to natural causes.

(b) Due To WINTHROP Board of Health

(c) Due To 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 Jan 31 1967

6 MONTIFIORE EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 1 1967

7 NAME OF FUNERAL DIRECTOR TORF Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed FEB 2 1967

John A. Clark
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of EDITH SIEGAL
(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 PRESSER
(Kind of work done during most of working life)

14 Industry or Business: GARMENT

15 Social Security No. 010-10-1454

16 BIRTHPLACE (City)..... RUSSIA
(State or country)

17 NAME OF FATHER ABRAHAM MOSHE SHAPIRO

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 SARAH MILLER

(Address) 19 CORAL Ave WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Richard Griffin
(Signature of Agent of Board of Health or other)Director of Public Health 1/31/67
(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.

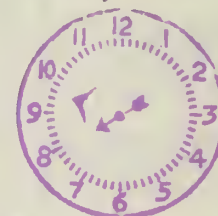
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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

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.

FEB 2 - '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

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. 15

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 MISS FLORENCE T 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)

(a) Permanent Residence. No. 146 COTTAGE PARK RD St. WINTHROP MASS

4

50

(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 31, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN. 14, 19.67 to JAN. 31, 1967
I last saw her alive on JAN. 30, 1967 death is said to
have occurred on the date stated above, at 12:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE-RT. WITH
LEFT HEMIPLEGIA(b) ARTERIO-SCLEROTIC + HYPERTENSIVE
HEART DISEASE

(c) GENERALIZED ARTERIO-SCLEROSIS 5 YRS.

OTHER
SIGNIFICANT
CONDITIONS BILATERAL BRONCHO-
PNEUMONIA

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 BARTLETT RD, WINTHROP, MASS.

Date: JAN 31, 1967

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 2 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed JAN 31 1967

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 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 82 Years 4 Months 10 Days If under 24 hours
Hours Minutes13 Usual Occupation Teacher retired
(Kind of work done during most of working life)

14 Industry or Business Public school

15 Social Security No. 013-36-5629

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 Lois Haywood

(Address) 1171 Boylston St. Boston

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

(Signature of Agent of Board of Health or other)

(Official Designation) Richard Griffin 1/31/67
(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
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).

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 31 '8

12



10

TOP, M

FORM R-303

SUFFOLK

(County)

WINTHROP

(City or Town)

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

WINTHROP

(City or Town making this return)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 16

En route to Winthrop Community Hospital

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

2 FULL NAME BETSEY DREW TOWER
 (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. 17 Ruscoe Road, St. Wilton, Connecticut
 City or town and State

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 31, 1967
 (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 skull. Cerebral contusion. Fracture of jaw.

5 Accident, suicide, or homicide (specify) Accident.
 Date and hour of injury January 31, 1967.
 3:40 A.M.
 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? Public Street.
 (Specify type of place)

Manner of Injury Passenger in motor-car which struck tree.
 (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.

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

(Address) Boston Date 1/31 1967

7 Forest Hills Crematory Boston
 Place of Burial or Cremation (City or State)

DATE OF BURIAL February 3, 1967

8 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons

ADDRESS Boston, Mass.

Received and filed FEB 2 1967

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)
 Female White 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 20 Years 4 Months 13 Days
 If under 24 hours
HoursMinutes

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

15 Industry or Business Northeast Airlines

16 Social Security No. 090-38-9418

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

18 NAME OF FATHER Frederic D. Tower

19 BIRTHPLACE OF FATHER (City) Newton
 (State or country) Mass.

20 MAIDEN NAME OF MOTHER Martha Chapman

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

22 Informant Mr. Frederic D. Tower
 (Address)
 17 Ruscoe Road, Wilton, Conn.

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

Richard Grissie (Inck.)
 (Signature of Agent of Board of Health or other)

Director of Public Health 2/3/67
 (Official Designation) (Date of Issue of Permit)

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT 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, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.
 100M-5-61-938000

PLACE OF DEATH

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

FEB 2 - '87 PM

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



OFFICE OF THE TOWN CLERK

WINTHROP, MASS.

RULES OF PRACTICE

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

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

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

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or 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.)"

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

(City or Town making this return)

17

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 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).

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No.

Duplex Nursing Home

2 FULL NAME

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

James P. Smitherman

(a) Permanent Residence. No.

95 BEACH RD

St.

WINTHROP

(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 9-9-66, 19, to 1-2-67, 19.

I last saw him on 1-1-66, death is said to have occurred on the date stated above, at 9 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute dilatation of Heart

(b) Carcinoma of Liver &

(c) metastasis.

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)

Elio Calicchio, M.D.
(Print or Type Name)

(Address)

7 Hancock St - Boston

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

DATE OF BURIAL

JAN 5

1966

7 NAME OF FUNERAL DIRECTOR

MAURICE W. HIRBY
210 WINTHROP ST
ADDRESS WINTHROP, MASS

Received and filed

JAN 6 1967

(Registrar)

STANDARD
CERTIFICATE OF DEATH

Registered No.

00072

(If death occurred in a hospital or institution, St. I 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

DIVORCED

UNKNOWN

MALE

WHITE

MARRIED

11 If married, widowed, or divorced

HUSBAND of SARA (CALLAHAN) SMITHERMAN
(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

Years

Months

Days

If under 24 hours

Hours Minutes

13 Usual Occupation

CARPENTER

(Kind of work done during most of working life)

14 Industry or Business

GENERAL

15 Social Security No.

16 BIRTHPLACE (City) WINSTON SALEM
(State or country) NORTH CAROLINA

17 NAME OF FATHER

UNKNOWN

18 BIRTHPLACE OF FATHER (City)

WINSTON - SALEM

(State or country)

NORTH CAROLINA

19 MAIDEN NAME OF MOTHER

UNKNOWN

20 BIRTHPLACE OF MOTHER (City)

WINSTON SALEM

(State or country)

NORTH CAROLINA

21 Informant

JAMES SMITHERMAN

(Address) 95 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:

TRUE COPY ATTEST:

William J. Kane.
City Registrar

+ 10 MAR
8 10 1

FEB 27 '67 AM



WINTHROP TOWN CLERK
WINTHROP, MASS.

SUFFOLK

(County)

BOSTON

(City or Town)


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

(City or Town making this return)

00126

 STANDARD
 CERTIFICATE OF DEATH

Registered No.

No. Massachusetts General Hospital BAKER MEMORIAL

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

PHYSICIAN — IMPORTANT

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

 2 FULL NAME Domenic T. Cardillo,
 (If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence. No. 14 Wadsworth Avenue, Winthrop. Massachusetts

(City or town and State)

Length of stay: In place of death.....years.....months.....6.....days. In place of residence.....5.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH January 3, 1967
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
December 28 1966 to January 3, 1967

 I last saw him on January 3, 1967 Death is said to

 have occurred on the date stated above, at 7:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Chronic Cor Pulmonale(b) Pulmonary Fibrosis(c) Asbestosis
 INTERVAL
 BETWEEN
 ONSET AND
 DEATH

1 Year

10 Years

20 Years

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
(Signature) C. C. Clay, M. D.
Charles L. Clay, M.D.
 (Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 1-4-67 1967
 6 Winthrop Cemetery, Winthrop
 Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 7 1967
 7 NAME OF
 FUNERAL DIRECTOR Anthony P. Rapino
ADDRESS 9 Chelsea St., East BostonReceived and filed JAN 10 1967

A TRUE COPY ATTEST:

(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 Josephine Ruggiero
 (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 Retired
 (Kind of work done during most of working life)

 14 Industry or Business *****
15 Social Security No. 032-01-5004
 16 BIRTHPLACE (City) Boston, Mass.
 (State or country)

 17 NAME OF
 FATHER Michael Cardillo

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

 19 MAIDEN NAME
 OF MOTHER Carmela Fortunato

 20 BIRTHPLACE OF
 MOTHER (City) Italy
 (State or country)
21 Informant Josephine Cardillo (wife)(Address) 14 Wadsworth Ave., Winthrop
 I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued.
Edith W. Hurd
 (Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

 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 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).

 Funeral Director
 Please use only
 BLACK Ink.

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

D - #1
not found

FEB 27 '67 AM



OFFICE OF THE TOWN CLERK
WINSTON, MASS

FORM R-301

The Commonwealth of Massachusetts

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

(City or Town making this return)

19

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. C0301

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 Angelo P. Screnci
(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. 51 Sargent Street St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, years months 1 days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 11 1967
(Month) (Day) (Year)I HEREBY CERTIFY That attended deceased from
Jan. 10 1967 to Jan. 11 1967

I last saw him live on Jan. 11 1967, death is said to

have occurred on the date stated above, at 12:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Heart Disease

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

(Signature) C. L. Clay, M.D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Jan. 11 1967

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

DATE OF BURIAL Jan 14 1967

7 NAME OF FUNERAL DIRECTOR Ernest Caggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed JAN 13 1967

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 ELINDA J FAVALORO
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 61 Years 5 Months 18 Days If under 24 hours
Hours Minutes13 Usual Occupation Retired Ins. Salesman
(Kind of work done during most of working life)

14 Industry of Business Insurance

15 Social Security No.

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Peter Screnci

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

19 MAIDEN NAME OF MOTHER Elizabeth Wardi

20 BIRTHPLACE OF MOTHER Elinda J Screnci
(State or country) 51 Sargent St Winthrop

21 Informant Elinda J Screnci (wife)

(Address) 51 Sargent St. Winthrop

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

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

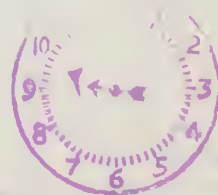
PRINT OR TYPE
CAUSE OR CAUSES
OF DEATHdo not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
the mode of dying,
such as heart failure,
asthenia, etc. It means
the disease, or compli-
cations which caused
death.Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.Conditions contrib-
uting to death but not
related to the terminal
disease condition given
in (a).Funeral Director
Please use only
BLACK Ink.

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

at 11:41

FEB 27 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

20

Suffolk

(County)

Boston

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No. C0420

No. Columbus 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) No2 FULL NAME Anastasia Lawler
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 50 Trident Ave St. Winthrop
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 14, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN, 1960, to JAN, 14, 1967.
I last saw her alive on JAN, 14, 1967, death is said to
have occurred on the date stated above, at 10:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYELOID LEUKEMIA

INTERVAL
BETWEEN
ONSET AND
DEATH
1 yr

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSHypertensive Arterio
Sclerotic Ht. Disease 6yrs

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 1/14/1967

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

DATE OF BURIAL January 17, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JAN 18 1967

William J. Kane

A TRUE COPY ATTEST

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN
Single11 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 Minutes13 Usual Occupation Cook
(Kind of work done during most of working life)

14 Industry or Business: Church Rectory

15 Social Security No.

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

17 NAME OF FATHER John Lawler

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

19 MAIDEN NAME OF MOTHER Catherine G. McAleney

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

21 Informant Robert Waidner Sr

(Address) 50 Trident 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)

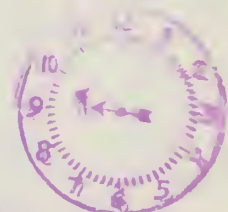
This does not mean
the mode of dying,
such as heart failure,
asthenia, etc. It means
the disease, or compli-
cations which caused
death.Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.Conditions contrib-
uting to death but not
related to the terminal
disease condition given
in (a).204-1
58
571
X

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

at 12:00
in R.B.
at 12:00

FEB 27 1874



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSChelsea 21
(City or Town making this return)PLACE OF DEATH
Suffolk
(County)
Chelsea.
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 28

Soldiers' Home Hospital

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

No. Frank Anthony WESSLING

PHYSICIAN — IMPORTANT

2 FULL NAME Frank Anthony Wessling
(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. 21 Enfield St

St. Winthrop
(City or town and State)

Length of stay: In place of death Hospital — years 1 months 9 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 21 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Dec. 12 66 to Jan. 21 67I last saw him alive on Jan. 21 1967, death is said to
have occurred on the date stated above, at 7:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) atherosclerotic heart disease

(b) Atherosclerotic heart disease

(c) (Chronic renal disease)

OTHER SIGNIFICANT CONDITIONS Chronic renal disease

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No(Signature) Joseph R. Datola, M. D.
JOSEPH R. DATOLA
(Print or Type Name)

(Address) CHELSEA SOLDIERS HOME Date JAN. 21 1967

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

DATE OF BURIAL Jan. 24 1967

7 NAME OF FUNERAL DIRECTOR ERNEST P. CREGGIANO

ADDRESS 147 WINTHROP ST. WINTHROP

Received and filed Jan. 24 1967

A TRUE COPY

(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 Margaret - Arsenault
(Give maiden name of wife in full)

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

12 AGE 70 Years 0 Months 9 Days If under 24 hours
Hours Minutes13 Usual Occupation Cetered Chauffeur.
(Kind of work done during most of working life)

14 Industry or Business Not known

15 Social Security No. 011-092-6548

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

17 NAME OF FATHER Bernard Wessling

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

19 MAIDEN NAME OF MOTHER Theresa Bogel.

20 BIRTHPLACE OF MOTHER (City) Germany
(State or country)21 Informant Cecile - Saline Haux
(Address) Chelsea, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Joseph R. Datola, M.D.
(Signature of Agent of Board of Health or other)AGENT BOARD OF HEALTH JAN. 21, 1967
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

1917 - 12 - 7

DATE OF DISCHARGE.....

1919 - 1 - 3

RANK, RATING.....

Pvt 1st Co Engns

ORGANIZATION AND OUTFIT.....

U. S. Army

SERVICE NUMBER.....

172-425

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 trauma (including resulting septicemia), and by the action of chemical (drugs, poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden 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 full entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, 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 24 67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

RECEIVED

JAN 24 1967

BOARD OF HEALTH

A TRUE COPY ATTEST:

John P. Davis

i O. k

FORM R-301

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

22

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

STANDARD

CERTIFICATE OF DEATH

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

PHYSICIAN — IMPORTANT

2 FULL NAME GEORGE J. WADLAND
(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. 30 BOWDOIN STREET 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 FEBRUARY 1, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JAN. 15, 1967 to Feb. 1, 1967
I last saw him live on Feb. 1, 1967, death is said to
have occurred on the date stated above, at 1:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Adenocarcinoma of Cecum 3 mos.

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS NoneWas autopsy performed? Yes
What test confirmed diagnosis? Pathological, postmortem5 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 2/1/1967

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

DATE OF BURIAL Feb 4 1967

7 NAME OF FUNERAL DIRECTOR Ernest Paggiano

ADDRESS 147 Wintthrop St Wintthrop

Received and filed FEB 3 1967

A TRUE COPY ATTEST:

(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 Anna G White
(Give maiden name of wife in full)

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

12 AGE 67 Years 7 Months 23 Days If under 24 hours
Hours Minutes13 Usual Occupation Retired Milkman
(Kind of work done during most of working life)

14 Industry or Business: Milk

15 Social Security No. 023-09-1846

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

17 NAME OF FATHER George Wadland

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

19 MAIDEN NAME OF MOTHER Mary O'Brien

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

21 Informant Mrs Anna Wadland

(Address) 30 Bowdoin St Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Richard Griffing
(Signature of Agent of Board of Health or other)
Div of Public Health 2/3/67
(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
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).

SUFFOLK

WINTHROP

WINTHROP COMMUNITY HOSPITAL

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

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

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
CAUSES 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

WINTHROP

(City or Town making this return)

SUFFOLK
(County)

WINTHROP

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No.

23

FULL NAME

VICTOR CIPRIANI

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

1/2 FULL NAME/ WINTHROP COMMUNITY HOSPITAL

PHYSICIAN — IMPORTANT

(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.

79 WINTHROP STREET

St. WINTHROP, Mass.

(City or town and State)

Length of stay: In place of death, years months 3 days. In place of residence 24 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEBRUARY 2, 1967 1966 -
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Nov. 1966 to Feb 2, 1967
I last saw him alive on Feb 2, 1967, death is said to
have occurred on the date stated above, at 6:50 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion

(b) Arteriosclerosis - generalized

(c)

OTHER SIGNIFICANT CONDITIONS Pulmonary infarct

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 H. Gregorie M. D.

(Address) 1940 Columbia Ave Date Feb 2, 1967

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

DATE OF BURIAL Feb 6, 1967

7 NAME OF FUNERAL DIRECTOR Ernest Plaggrano

ADDRESS 147 Wintthrop St Wintthrop

Received and filed FEB 3 1967 19

A TRUE COPY ATTEST:

(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 Louise De Santo
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 61 Years 8 Months 8 Days If under 24 hours
Hours Minutes13 Usual Occupation Shoe Worker
(Kind of work done during most of working life)

14 Industry or Business Shoe Mfg.

15 Social Security No. 022-09-4641

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER John Cipriani

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

19 MAIDEN NAME OF MOTHER Lucy Petronantoni

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Louise (De Santo) Cipriani
(Address) 79 Wintthrop St WintthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Richard Griffis
(Signature of Agent of Board of Health or other)
Ser of Public Health 2/3/67
(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.

FORM R-301

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
(City or Town)
No. 116 COURT RDSTANDARD
CERTIFICATE OF DEATH

Registered No. 24

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

PHYSICIAN — IMPORTANT

2 FULL NAME JEREMIAH E 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.) W.W.II(a) Permanent Residence. No. 116 COURT RD St. WINTHROP, Mass.
(Usual place of abode) (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 February 9 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Sept. 2, 1960, to Feb. 9, 1967.I last saw him alive on Feb. 8, 1967, death is said to
have occurred on the date stated above, at 7:10 a.m.DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Advanced rheumatic heart
disease with aortic stenosis
and mitral insufficiency 7 yrs

(a) Due To none

(b) none

(c) none

OTHER SIGNIFICANT CONDITIONS
Embolism to splenic artery with infarction 8 wks.

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) M. Traunstein, Jr., M.D.

(Address) 73 Bartlett Road Wintthrop, Mass. Date 2-10-1967

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

DATE OF BURIAL FEB 11 1967

7 NAME OF FUNERAL DIRECTOR MARRICE W KIRBY

ADDRESS WINTHROP, MASS.

Received and filed FEB 10 1967

(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 MARY GOGAN
(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 LAWYER
(Kind of work done during most of working life)

14 Industry or Business LAW, PROBATE

15 Social Security No.

16 BIRTHPLACE (City) DO BOSTON
(State or country) MASS

17 NAME OF FATHER TIMOTHY SULLIVAN

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

19 MAIDEN NAME OF MOTHER ANNIE MC DONOUGH

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

21 Informant MARY (GOGAN) SULLIVAN

(Address) 116 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:Richard Griffin
(Signature of Agent of Board of Health or other)Sir of Public Health
(Official Designation) (Date of Issue of Permit)filed for burial permit
by Board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATEINT OR TYPE
SE OR CAUSES
OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)is does not mean
mode of dying,
as heart failure,
mia, etc. It means
disease, or compli-
cations which caused
it.Conditions, if any,
which gave rise to
above cause (a),
listing the under-
lying cause last.Conditions contrib-
uting to death but not
leading to the terminal
disease condition given
(b).

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE..... 23 FEB 42
DATE OF DISCHARGE..... 30 NOV 45
RANK, RATING..... TEC 5
ORGANIZATION AND OUTFIT..... INF ARMY
SERVICE NUMBER..... 31067908

RULES OF PRACTICE

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

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

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

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

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

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

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

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-5-64-938000

PLACE OF DEATH
1
Suffolk
(County)
Revere
(City or Town)



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

Revere
(City or Town making this return)
25
Registered No.

COPY OF
CERTIFICATE OF DEATH

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

2 FULL NAME Philip L. Anderson
(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 11 Summit Ave. St. Winthrop
(City or town and State)

Length of stay: In place of death 1 years.....months.....days. In place of residence 43 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 11, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 63, to Feb. 11, 1967.
I last saw him alive on Jan. 67, death is said to have occurred on the date stated above, 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebro vascular occlusion 6mons.
Due To Cerebral arterio-sclerosis 2yrs.
Due To
(c) OTHER SIGNIFICANT CONDITIONS Pulmonary tuberculosis 3yrs.

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.
Winthrop Shore Dr. 2/13/67
(Address) Winthrop

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 15 67

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

Received and filed MAR 8 1967
John Clark
(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 widwed

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

12 AGE 85 Years.....Months.....Days If under 24 hoursHours.....Minutes

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

14 Industry or Business: Boston Elevated

15 Social Security No.

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

PARENTS
17 NAME OF FATHER Patrick J. Anderson
18 BIRTHPLACE OF FATHER (City) Galway
(State or country) Ireland
19 MAIDEN NAME OF MOTHER Ellen Finnegan
20 BIRTHPLACE OF MOTHER (City) Glasgow
(State or country) Scotland

21 Informant Philip L. Anderson, Jr.
(Address) 6 Smith Way, Hingham

A TRUE COPY Joseph P. [Signature]
ATTEST: (Registrar of City or Town where death occurred)
DATE FILED February 14, 1967

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

MAR 8 '67 AM



OFFICE OF THE
WINT

FORM R-301

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 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 given
in (a).

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 17 Palmyra St.

2 FULL NAME Marion A Kelleher
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 17 Palmyra St.,
St. Winthrop, Mass.
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 11, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov. 19.63 to 2/11/1967
I last saw her alive on 2/10/1967 death is said to
have occurred on the date stated above, at 10:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

(b) Hypertensive Arterio-

(c) Due To Sclerotic 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 2/11/1967

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

DATE OF BURIAL February 14 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed FEB 13 1967 19

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHL WINTHROP
(City or Town making this return)

Registered No. 26

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

PHYSICIAN — IMPORTANT

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

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Leo Kelleher
(Husband's name in full)12 AGE 69 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) Winthrop
(State or country) Mass

17 NAME OF FATHER Joseph L. Visall

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

19 MAIDEN NAME OF MOTHER Mary J. Crowley

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass21 Informant Leo Kelleher
(Address) 17 Palmyra Street WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Veleghiano (Signature of Agent of Board of Health or other)
Dir. of Public Health Feb 13, 1967
(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.

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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. 27

No. 14 Waldemar Ave

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

2 FULL NAME

James A. Kirley

(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. 14 Waldemar Ave.

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

Length of stay: In place of death 12 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 11, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Sept. 13, 1964, to Feb. 11, 1967.

I last saw him on Jan. 3, 1967, death is said to
have occurred on the date stated above, at 9:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease

(b) Generalized arteriosclerosis

(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) 27 Pennington St. Date Feb. 13, 1967
Revere, Massachusetts 02151

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

DATE OF BURIAL February 14, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed FEB 13 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 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 78 Years Months Days If under 24 hours
Hours Minutes

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

14 Industry or Business: Town of Winthrop

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

17 NAME OF FATHER James Kirley

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

19 MAIDEN NAME OF MOTHER Maria Murray

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

21 Informant Agnes Murphy
(Address) 14 Waldemar Ave., Winthrop

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

Philip S. Magliano (Signature of Agent of Board of Health or other)
Dir. of Public Health Feb 13 1967
(Official Designation) (Date of Issue of Permit)

Medical Examiner Waived Jurisdiction:

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 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).

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.

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



WINTHROP
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 28

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 114 Lincoln Street

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

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

PHYSICIAN — IMPORTANT

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

(a) Permanent Residence. No. 114 Lincoln Street
St. Winthrop, Mass.
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 11 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h..... alive on....., 1967, death is said to
have occurred on the date stated above, at 11:02 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

(b) to natural causes.

(c) Due To

WINTHROP BOARD of Health

OTHER
SIGNIFICANT
CONDITIONS

Charles Liberman and

Was autopsy performed? no

What test confirmed diagnosis? no

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) 238 Shore Drive Date 2/11/67
Winthrop, Mass.

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 14, 1967 19

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St. E. Boston

Received and filed FEB 13 1967 19

A TRUE COPY ATTEST:

(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 Pearl I. Rempel
(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 Brakeman retired
(Kind of work done during most of working life)

14 Industry or Business B. & M Railroad

15 Social Security No. 028-03-3125

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

17 NAME OF FATHER Harvey W. Page

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

19 MAIDEN NAME OF MOTHER Catherine Davis

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

21 Informant Mrs. Pearl I. Page-wife

(Address) 114 Lincoln St., Winthrop

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

Philip G. Vitagliano (R)
Signature of Agent of Board of Health (or other)
Sir of Public Health Feb 13, 1967
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... Nov. 30, 1942

DATE OF DISCHARGE..... Feb. 13, 1946

RANK, RATING Staff Sgt.

ORGANIZATION AND OUTFIT..... U. S. Army

SERVICE NUMBER..... 31 233 372

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.

Suffolk

(County)

Winthrop

(City or Town)

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

WINTHROP

(City or Town making this return)

29

STANDARD
 CERTIFICATE OF DEATH

Registered No.

Filed for burial permit
 in Board of Health
 or its Agent.

INSTRUCTIONS
 FOR
 LOCAL CERTIFICATE

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 PAUL L. CRUESS

(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. 188 Bellingham Avenue
 (Usual place of abode)

St. Revere
 (City or town and State)

Length of stay: In place of death.....years.....months.....14 days. In place of residence 42 years.....months.....days.

INT 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,
 pneumonia, etc. It means
 disease, or compli-
 ns which caused

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

Conditions contrib-
 uting to death but not
 related to the terminal
 disease condition given
 (b).

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 12, 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
 Dec. 12, 1966, to Feb. 12, 1967.
 I last saw him alive on Feb. 12, 1967, death is said to
 have occurred on the date stated above, at 8:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of liver (Hematoma)

INTERVAL
 BETWEEN
 ONSET AND
 DEATH

2 months

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS
 Evisceration of abdominal
 wound 2/9/1967

Was autopsy performed? no
 What test confirmed diagnosis? Pathology report.

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 St., Date Feb. 13, 1967

Holy Cross Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL 2/15/67

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave., Revere

Received and filed FEB 14 1967

(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 Marguerite F. Francis
 (Give maiden name of wife in full)

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

12 AGE 67 Years 9 Months 19 Days If under 24 hours
 Hours Minutes

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

14 Industry or Business School

15 Social Security No.....
 16 BIRTHPLACE (City) Waterbury Conn.
 (State or country)

17 NAME OF FATHER John F. Cruess

18 BIRTHPLACE OF FATHER (City) New Hartford Conn.
 (State or country)

19 MAIDEN NAME OF MOTHER Mary Horan

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

21 Informant Marguerite F. Cruess
 (Address) 188 Bellingham Ave., Revere

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

Philip G. Vitiello
 (Signature of Agent of Board of Health or other)
 Director of Public Health Feb 14, 1967
 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE..... 9/ 30/ 18
DATE OF DISCHARGE..... 12/ 13/ 18
RANK, RATING..... Private
ORGANIZATION AND OUTFIT..... Student Army Training Corps
SERVICE NUMBER..... 5- 125- 769
.....

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

Monson
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 30

No. MONSON STATE HOSPITAL

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

2 FULL NAME **CLAIRE A. ADAMS**
(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. **Winthrop, Mass.**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. **39** years **0** months **21** days. In place of residence. **28** years **1** months **19** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **February 13 1967**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw him/her on **Feb. 13**....., 19**67** death is said to
have occurred on the date stated above, atm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Bronchopneumonia**

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS **Epilepsy**

INTERVAL
BETWEEN
ONSET AND
DEATH

1 week

61 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

(Signed) **George M. Reis M.D.**....., M. D.

(Address) **Monson State Hospital 2/13**....., 19**67**

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

DATE OF BURIAL **February 16**....., 19**67**

7 NAME OF FUNERAL DIRECTOR **Vincent J. Mazzarella**

ADDRESS **971 Saratoga St. E. Boston, Mass.**

Received and filed **FEB 20 1967**....., 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 **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 **67** Years **2** Months **10** Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: **none**
(Kind of work done during most working life)

14 Industry or Business: **none**

15 Social Security No.
16 BIRTHPLACE (City) **East Boston, Mass.**
(State or country)

17 NAME OF FATHER **Frederick S. Adams**

18 BIRTHPLACE OF FATHER (City) **St. Johns**
(State or country) **Newfoundland**

19 MAIDEN NAME OF MOTHER **Elizabeth A. Dunn**

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

21 Informant **Monson State Hospital Records**
(Address)

A TRUE COPY

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

DATE FILED **FEB 15 1967**....., 19.....

PLACE OF DEATH

1

Hampden
(County)

Monson Mass.

(City or Town)

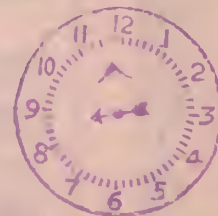


WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town or 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.....
.....

FEB 20 '67 AM



OFFICE OF THE JUDGE CLERK
WINTHROP, MASS.

FORM R-301

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 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).

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

31

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 Phillip, Ashman
(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

2 Brimblecomb St., Lynn, Mass.
(a) Permanent Residence. No. ~~Cliff House Nursing Home~~ St. ~~Winthrop, Mass.~~
(City or town and State)

Length of stay: In place of death, years, months, 4 days. In place of residence 65 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEBRUARY 16, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
10/20, 1966, to FEB 16, 1967

I last saw him alive on 2/15/1967, death is said to
have occurred on the date stated above, at 3:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) NEPHROSCLEROSIS WITH
UREMIA

(b) ARTERIO SCLEROSIS AND
ATHEROSCLEROTIC HEART DIS

(c) CHRONIC BRONCHITIS,
BRONCHIECTASIS +
EMPHYSEMA

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) *Theron N. King*, M. D.

Theron N. King MD
(Print or Type Name)

(Address) 20 Pleasant St. Date 2/16 1967
WINTHROP MASS

6 *Prize of Lynn* LYNN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 17, 1967

7 NAME OF FUNERAL DIRECTOR *Edward M. Hymanson*

ADDRESS *Lynn, Mass.*

Received and filed FEB 16 1967

A TRUE COPY ATTEST:

(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 MIRIAM PERKINS
(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
(Kind of work done during most of working life)

14 Industry or Business: Builder

15 Social Security No. none

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER JOSEPH ASHMAN

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

19 MAIDEN NAME OF MOTHER BESSIE C.B.L.

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

21 Informant MAX ASHMAN

(Address) 9 Ocean Side Terrace
SWAMPSCOTT

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

Philip J. Delaghiavo
(Signature of Agent of Board of Health or other)

Director of Public Health - Feb 16, 1967
(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.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSL WINTHROP
(City or Town making this return)

PLACE OF DEATH

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

Registered No. 32

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
leading to the terminal
disease condition given
(b).1 No. The Cliff House Nursing Home
2 FULL NAME William Cronin
(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. 162 Washington Ave St WINTHROP, MASS.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 3 months 0 days. In place of residence 37 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 16 1967
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from
May 1964, to Feb. 16, 1967
I last saw him alive on Feb. 15, 1967, death is said to
have occurred on the date stated above, at 7:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

(b) Arterio Sclerosis Generalized

(c)

INTERVAL
BETWEEN
ONSET AND
DEATHyrs
mos
wksOTHER
SIGNIFICANT
CONDITIONSWas 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 J. Gregor M. D.
(Print or Type Name)
(Address) 194 Washington Ave Date 2-16-676 WINTHROP WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 20 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 WINTHROP ST WINTHROP

Received and filed FEB 20 1967

John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN SINGLE11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

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

12 AGE 85 Years 11 Months 16 Days If under 24 hours
Hours Minutes13 Usual Occupation Laborer
(Kind of work done during most of working life)

14 Industry or Business Fort Banker

15 Social Security No. 023-16-9685

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

17 NAME OF FATHER John J. Cronin

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

19 MAIDEN NAME OF MOTHER Anna Sullivan

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Albert Wyman
(Address) 162 Wash Ave WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Philip S. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 2/17/67
(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.

FORM R-301

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

33

PLACE OF DEATH

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

Registered No.

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

PHYSICIAN - IMPORTANT

2 FULL NAME BELBIN, ALICE M. (LASQUIE)
(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) Permanent Residence. No. 671 SOMERVILLE St. SOMERVILLE, MASS
(City or town and State)

Length of stay: In place of death 0 years 0 months 1 days. In place of residence 10 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 18 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
1/27, 1967, to FEB 18, 1967.
I last saw her alive on FEB 18, 1967, death is said to
have occurred on the date stated above, at 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO-SCLEROTIC HEART DISEASE WITH
(b) CONGESTIVE HEART FAILURE
1 DAYDue To
(c)

OTHER SIGNIFICANT CONDITIONS 2. PULMONARY INFARCTION 1 DAY

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL + X-ray5 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 MD

(Address) 220 VLEIGH ST. WINTHROP MASS
Date FEB 19 19676 GETHSEMANE WEST ROXBURY
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 21 1967

7 NAME OF FUNERAL DIRECTOR FRANCIS H. BROWN

ADDRESS 34 BOW ST. SOMERVILLE

Received and filed FEB 20 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

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 ALFRED S. BELBIN (Husband's name in full)

12 AGE 54 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) NEW BRUNSWICK CANADA (State or country)

17 NAME OF FATHER HIRAM LASQUIE

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

19 MAIDEN NAME OF MOTHER JANE WHELPEY

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

21 Informant ELSIE A RIVERS (DAUGHTER)

(Address) 671 SOMERVILLE AVE, SOMERVILLE

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) Director of Public Health (Date of Issue of Permit) 2/20/67

N.I.V. EXHIBIT 112 DECLINED JURISDICTION

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).

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

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. 34

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 Marie J. McGeorge
(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. 189 Pleasant St.
(Usual place of abode)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 Feb. 18, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
2/17/1967, to 2/18/1967.I last saw he alive on 2/17/1967, death is said to
have occurred on the date stated above, at 3:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

(b) Cerebral Arteriosclerosis

(c) Due To

INTERVAL
BETWEEN
ONSET AND
DEATH

2 Days

2 yrs

OTHER
SIGNIFICANT
CONDITIONSARTERIOSCLEROTIC
HEART DISEASE.

3 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

Charles LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 2/18/1967

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

DATE OF BURIAL February 21, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

Winthrop, Mass

Received and filed FEB 20 1967

John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William McGeorge
(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 of working life)

14 Industry or Business Own Home

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

17 NAME OF FATHER Henry Rogers

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

19 MAIDEN NAME OF MOTHER Sophia Murphy

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant William McGeorge
(Address) 189 Pleasant St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Magliano
(Signature of Agent of Board of Health or other)
Director of Public Health Feb 20, 1967
(Official Designation) (Date of Issue of Permit)

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

RULES OF PRACTICE

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

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

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

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

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

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

The Commonwealth of Massachusetts

FORM R-301

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)PLACE OF DEATH
1Suffolk
(County)Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 35

No. Viking Nursing Home

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

PHYSICIAN — IMPORTANT

2 FULL NAME Ada Pepper Tansley
(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. 110 Grovers Avenue st. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....1 months.....9 days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 18 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
AUG. 20, 19. 63 to FEB. 18, 19. 67
I last saw her alive on FEB. 17, 1967. death is said to
have occurred on the date stated above, at 3:40 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction 5 days
(b) Due To Arteriosclerotic + Hypertensive heart Disease 5 YRS.
(c) Generalized Arteriosclerosis 7 YRS.INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
SIGNIFICANT
CONDITIONS NoneWas autopsy performed? No
What test confirmed diagnosis? Clinical + Laboratory5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) M. Trauneite M.D.
M. TRAUNITEI, JR. M.D.
(Print or Type Name)
(Address) 73 Bartlett Rd. Winthrop, Mass. Date Feb. 18, 19. 676 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 21, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 21 1967

A TRUE COPY ATTEST:

(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 George Tansley
(Husband's name in full)12 AGE 86 Years 0 Months 1 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. 010-09-6869

16 BIRTHPLACE (City) England
(State or country)

17 NAME OF FATHER Thomas Pepper

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

19 MAIDEN NAME OF MOTHER Mary Taylor

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

21 Informant Welfare Dept. Records

(Address) Winthrop Town Hall

I HEREBY CERTIFY that a satisfactory standard certificate of death
has been filed with me BEFORE the burial or transit permit was issued:Philip B. Vitagliano
(Signature of Agent of Board of Health or other)
Dir of Public Health Feb 21, 1967
(Official Designation) (Date of Issue of Permit)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).

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

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. 36

WINTHROP COMMUNITY HOSPITAL

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

MRS. FREIDA R. PRESCOTT

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)

118 QUINCY AVE. WINTHROP MASS.

(a) Permanent Residence. No. (City or town and State)

Length of stay: In place of death years months 9 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 20 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
2/11 1967, to 2/20 1967

I last saw her alive on 2/19 1967, death is said to
have occurred on the date stated above, at 6:20 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

Due To (b) ARTERIO SCLEROTIC HEART DIS

Due To (c) CONGESTIVE FAILURE

OTHER SIGNIFICANT CONDITIONS (d) DIABETES MELLITUS

INTERVAL
BETWEEN
ONSET AND
DEATH
9 HRS

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) Myron M. King, M. D.

(Print or Type Name) MYRON M. KING M.D.

(Address) 222 PLETHORE ST. WINTHROP MASS. Date 2/20 1967

6 Winthrop Cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 23, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed FEB 21 1967

(Registrar)

A TRUE COPY ATTEST:

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

(or) WIFE of Carl O. Prescott (Give maiden name of wife in full) (Husband's name in full)

12 AGE 66 years 5 Months 19 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. 023-09-1810-B

16 BIRTHPLACE (City) Milford (State or country) New Hampshire

17 NAME OF FATHER Frederick Reilly

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

19 MAIDEN NAME OF MOTHER Peckinough

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

21 Informant Carl O. Prescott

(Address) 118 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:

Philip B. Vatsianos (Signature of Agent of Board of Health or other)

Sir of Public Health Feb 21 1967 (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.

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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.

FORM R-301

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. 37

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

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

789 Shirley Street

(a) Residence. No.
(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 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 21 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN., 1965, to Feb. 21, 1967.

I last saw he/she alive on 2/20, 1967 death is said to
have occurred on the date stated above, at 5:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

INTERVAL
BETWEEN
ONSET AND
DEATH
1 wk.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS Generalized Arterio
Sclerosis 10 yrs

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 2/21/1967

6 Mount Hope Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 24 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed FEB 23 1967

(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 Arthur F Bowes
(Give maiden name of wife in full)

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

12 99 10 26
AGE.....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) Halifax
(State or country) Nova Scotia

17 NAME OF FATHER Joseph Osborne

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

19 MAIDEN NAME OF MOTHER Elizabeth Cleary

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

21 Informant Francis C Bowes

1 Stonehill Dr. Stoneham, Mass
(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) 2/24/67

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

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)

No. WINTHROP COMMUNITY HOSPITAL

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

2 FULL NAME **RUTLEDGE ARTHUR H.**
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)

35 PROSPECT AVE.

WINTHROP, MASS.

(a) Permanent Residence. No.

St.

(City or town and State)

Length of stay: In place of death.....years.....months⁹.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 21 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Dec 10, 1966, to Feb 21, 1967I last saw him live on 2-20, 1967, death is said to
have occurred on the date stated above, at 5-11 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

(b) hypertensive heart disease

(c)

OTHER SIGNIFICANT CONDITIONS Duodenal ulcer

Was autopsy performed? no
What test confirmed diagnosis? CCG lab5 Was disease or injury in any way related to occupation of deceased?
If so, specify yes - onset smoking snow(Signature) *Arthur H. Rutledge*, M. D.

(Address) 447 South St., Wintthrop, Mass. Date 2-21-1967

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

DATE OF BURIAL February 24, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 24 1967

John A. Clark (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 Gladys Evelyn Whitehead
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 56 Years 5 Months 26 Days If under 24 hours
Hours Minutes13 Usual Occupation Mechanic
(Kind of work done during most of working life)

14 Industry or Business: Retail car repair Co.

15 Social Security No. 023-09-5897

16 BIRTHPLACE (City) Ireland
(State or country)

17 NAME OF FATHER Harry Rutledge

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

19 MAIDEN NAME OF MOTHER Elizabeth Dixon

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

21 Informant Mrs. Arthur H. Rutledge

(Address) 35 Prospect Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
has been filed with me BEFORE the burial or transit permit was issued:*Philip S. Vitagliano*
(Signature of Agent of Board of Health or other)*Dir. of Public Health* Feb 24 1967
(Official Designation) (Date of Issue of Permit)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).

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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 39

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

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 Helen Fairfield Tewksbury
(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. 39 Edgehill Road St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 2 years 3 months days. In place of residence 62 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 22, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
AUG 17, 1957, to FEB 22, 1967
I last saw her alive on FEB 22, 1967 death is said to
have occurred on the date stated above, at 4:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic + hypertensive heart disease 7 yrs.

(b) Generalized Arteriosclerosis 10 yrs.

(c) —

OTHER SIGNIFICANT CONDITIONS Hypertrophic Arteritis 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. Traustein M. D.

(Print or Type Name) M. TRAUSTEIN M.D.

(Address) 73 Bartlett Rd. Date FEB 22, 1967
Winthrop6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 25, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 24 1967

A TRUE COPY ATTEST:

(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 Melbourne Banks Tewksbury
(Husband's name in full)12 AGE 87 Years 6 Months 26 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. 018-30-3370

16 BIRTHPLACE (City) Lyme
(State or country) New Hampshire

17 NAME OF FATHER Preston L. Fairfield

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

19 MAIDEN NAME OF MOTHER Churchill

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

21 Informant Earl F. Tewksbury

(Address) 39 Edgehill Road

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano &
(Signature of Agent of Board of Health or other)Director of Public Health FEB 24 1967
(Official Designation) (Date of Issue of Permit)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).

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

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

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

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

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

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

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

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

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

STANDARD CERTIFICATE OF DEATH

Registered No

40

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

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 MR VINCENT DIGIROLAMO
(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. 35 CRESCENT AVE
(Usual place of abode)

REVERE MASS
(If nonresident, give city or town and State)

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

INSTRUCTIONS
FOR
C. CERTIFICATE

giving
S OF 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

ons, 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
to print or
e cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
ier signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 24 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
JULY 13 1965 to FEB 24 1967
I last saw him alive on FEB 21 1967, death is said to
have occurred on the date stated above, at 1045 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY INFARCTION

Due To (b) ARTERIOSCLEROTIC HEART DIS.

CHRONIC BRONCHITIS

Due To (c) CHRONIC BRONCHITIS

EMPHYSEMA

OTHER SIGNIFICANT CONDITIONS CHRONIC HYPERTENS

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

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

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

MYRON N. KING
(PRINT OR TYPE SIGNATURE)

(Address) 221 PLEASANT ST. Date 2/24/67

6 ST. MARY'S CANTON MASS.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 2/27/67

7 NAME OF FUNERAL DIRECTOR JOSEPH P. ROACHE

ADDRESS 110 SHERMAN ST. CANTON MASS.

Received and filed John A. [Signature] FEB 24 1967

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

10a If married, widowed, or divorced
HUSBAND of MARY CARO
(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 — Minutes —

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

14 Industry or Business: DRAPER CO.

15 Social Security No. 025-01-3803

16 BIRTHPLACE (City) BARDI
(State or country) ITALY

17 NAME OF FATHER PATSY DIGIROLAMO

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

19 MAIDEN NAME OF MOTHER C. N. B. L.

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

21 Informant VINCENT J. DIGIROLAMO
(Address) 35 CRESCENT AVE REVERE MASS.

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

Philip G. Velaghaman
(Signature of Agent of Board of Health or other)

Director of Public Health 2/24/67
(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.

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

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

SUFFOLK

(County)

WINTHROP

(City or Town)


 SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

 MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No. 41

No. 497A Shirley St., Winthrop

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

2 FULL NAME GEORGE

(First Name)

H.

(Middle Name)

INGRAHAM

(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. 497A Shirley Street, Winthrop, Mass.

(City or town and State)

Length of stay: 1. of death 4 years months days. In place of residence 4 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 24, 1967
(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.
Diabetes mellitus.

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.

Michael A. Luongo, M.D.

(Address) Boston (Print or Type Name) Date 2/24 1967

7 Mt. Auburn Cemetery Cambridge, Mass.

Place of Burial or Cremation.

(City or Town)

DATE OF BURIAL March 1 1967

8 NAME OF FUNERAL DIRECTOR Mildred S. Conroy

ADDRESS 439 Washington St., Newton, Mass.

Received and filed FEB 28 1967 19

A TRUE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Divorced

12 If married, widowed, divorced
HUSBAND of Helen Kenney

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 67

Year Months Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

Salesman Ret.

(Kind of work done during most of working life)

15 Industry

(or Business):

Insurance Life

16 Social Security No.

023 09 2203

17 BIRTHPLACE (City)

Fonda

(State or country)

New York

18 NAME OF

FATHER

Howard Ingraham

19 BIRTHPLACE OF

FATHER (City)

Troy

(State or country)

New York

20 MAIDEN NAME

OF MOTHER

Helen (Taylor) Ingraham

21 BIRTHPLACE OF

MOTHER (City)

Troy

(State or country)

New York

22 Informant William F. Ingraham

(Address)

152 Brookside Drive

Fairfield, Connecticut

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

Philip G. Vitashiano

(Signature of Agent of Board of Health or other)

Dir of Public Health Feb 28, 1967

(Official Designation)

(Date of Issue of Permit)

 NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT
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.

100W-5-64-938000

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

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 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).

The Commonwealth of Massachusetts

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



WINTHROP

(City or Town giving this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 42

1 PLACE OF DEATH Suffolk (County)
WINTHROP (City or Town)
Wintthrop Community Hospital No. _____ St. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Leo J. MILLER
(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 Nevada St. WINTHROP, Mass.
(City or town and State)

Length of stay: In place of death 1 1/2 years 12 months 17 days. In place of residence 17 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 24 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased, from MAY 13 1957 to FEB 24 1967
I last saw him alive on FEB 24 1967 death is said to have occurred on the date stated above, at 6:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL INFARCTION
(b) ARTERIOSCLEROTIC HEART
(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) Myron N. King M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) WINTHROP MASS Date 2/24 1967

6 Tifereth ds. of Wintthrop - Bennett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 26 1967

7 NAME OF FUNERAL DIRECTOR TORF funeral Service Inc

ADDRESS 151 Washington Ave Chelsea

Received and filed FEB 27 1967

A TRUE COPY ATTEST:

(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 BEATRICE MAGID
(Give maiden name of wife in full)

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

12 49 Years 0 Months 0 Days If under 24 hours
AGE 0 Hours 0 Minutes

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

14 Industry or Business Pharmacy

15 Social Security No. 012-69-0387

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

17 NAME OF FATHER MORRIS MILLER

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

19 MAIDEN NAME OF MOTHER MOLLIE — C.B.L.

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

21 Informant Martin Miller

(Address) 33 Nevada St WINTHROP

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

Philip S. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 2/26/67
(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.

FORM R-301

ed for burial permit
Board of Health
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,
ja, etc. It means
cause, or compli-
sease, which caused

ditions, 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

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 39 PALMYRA STREET

FULL NAME

DONATO CAMPARARO

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

39 PALMYRA ST.

(a) Re

No.

(1) place of abode)

Length of stay: 4 e of death 5 years months days. In place of residence 5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 26 1967
(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 4:20 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To (b) natural causes

Due To (c) 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? No.
If so, specify

(Signature) Charles Liberman M.D.

(Print or Type Name)

(Address) 238 SHORE DR. Date 2/26/67

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

DATE OF BURIAL 2-MARCH 19 67

7 NAME OF FUNERAL DIRECTOR ERNEST P. CAGGIANO

ADDRESS 147 WINTHROP ST. WINTHROP

Received and filed MAR 2 1967

(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. 43

(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) 1.0

WINTHROP, Mass.

(City or town and State)

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 FLORENCE FORLANI (Give maiden name of wife in full)

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

12 AGE 72 Years 0 Months 26 Days If under 24 hours Hours Minutes

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

14 Industry or Business CHILDREN'S MED CENTER

15 Social Security No. 031-10-956

16 BIRTHPLACE (City) ITALY (State or country)

17 NAME OF FATHER NICHOLAS CAMPARARO

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

19 MAIDEN NAME OF MOTHER PASQUALINA MADIO

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

21 Informant LENA CAMPARARO

(Address) 39 PALMYRA ST.

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

Philip G. Tagliano (M.D.) (Signature of Agent of Board of Health or other)

Director of Public Health 3/1/67 (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

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 44

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. KIRKING NURSING HOME

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

PHYSICIAN — IMPORTANT

2 FULL NAME ANNA M (GLEASON) SMITH
(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. 2 EDGAR TERRACE
(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 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 26 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
9/22/1954 to Feb. 26 1967I last saw her alive on Feb. 25 1967, death is said to
have occurred on the date stated above, at 5:45a.m.DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Arteriosclerotic & hyper-
tensive heart disease(a) Due To Generalized arterio-
(b) scleroticINTERVAL
BETWEEN
ONSET AND
DEATH

7yrs

(c) Due To

9yrs

OTHER SIGNIFICANT CONDITIONS
Recurrent phlebitis
cystitis.
Chronic gastritis

2yrs

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, Jr. M. D.
(Print or Type Name)(Address) 73 Bartlett Rd. Date 2-27 1967
Wintthrop, Mass.6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 1 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W HIRBY

ADDRESS WINTHROP MASS

Received and filed FEB 28 1967 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN WIDOWED11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of FREDERICK M SMITH
(Husband's name in full)12 AGED 66 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. 025-18-5625

16 BIRTHPLACE (City) NEW BRUNSWICK
(State or country) CANADA

17 NAME OF FATHER CHRIS GLEASON

18 BIRTHPLACE OF FATHER (City) NEW BRUNSWICK
(State or country) CANADA

19 MAIDEN NAME OF MOTHER ANNA GIBBONS

20 BIRTHPLACE OF MOTHER (City)
(State or country) CANADA21 Informant DOROTHY E COFFEY
(Address) 2 EDGAR TERRACE WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)Director of Public Health 2/28/67
(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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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

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

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 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).

OUT - OF - TOWN

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.

No. Peter Bent Brigham Hospital

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

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

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. W. Veteran
if so specify WAR.

10

(a) Permanent Residence. No. 2 Edgar Terr. St. Winthrop, Mass.

(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 January 27, 1967.
(Month) (Day) (Year)

4 I HEREBY CERTIFY That We attended deceased from
Jan. 22, 1967, to Jan. 27, 1967.

We last saw him alive on Jan. 27, 1967, death is said to
have occurred on the date stated above, at 2:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Subarachnoid hemorrhage

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? no
If so, specify

(Signature) S. Ralph Himmelhoch M. D.

(Address) PBBH Date Jan. 27, 1967.

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

DATE OF BURIAL Jan. 30, 1967.

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

Received and filed FEB 1 1967

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 Eva King
(Give maiden name of wife in full)

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

12 52 11 13 GE Years Months Days If under 24 hour
Hours Minutes

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

14 Industry or Business Simmons College

15 Social Security No. 364 18 3556

16 BIRTHPLACE (City) Alpena Mich.
(State or country)

17 NAME OF FATHER John Hart

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

19 MAIDEN NAME OF MOTHER Martha Rondeau

20 BIRTHPLACE OF MOTHER (City) Spruce
(State or country) Mich.

Eva Hart

21 Informant 38 Revere 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:

7-K Shaca 005444
(Signature of Agent of Board of Health or other)

(Official Designation) JALM 30/1967
(Date of Issue of Permit)

A TRUE COPY ATTEST:

1967 MAR 14

William J. Kane.
City Registrar

MAR 14 '67 AM



CITY OF WINTHROP
WINTHROP MASS.

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 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).

450
85

PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)

No. **New England Deaconess Hospital**
Everett

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

(City or Town making this)

STANDARD
CERTIFICATE OF DEATH

Registered No.

2 FULL NAME **Mr. Almon E. Whittemore**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. **55 Orlando Ave.** St. **Winthrop, Mass.**
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence **64** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **February 1 1967**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
NOV 3, 19**56**, to **Feb. 1**, 19**67**
I last saw him alive on **Jan. 31**, 19**67**, death is said to
have occurred on the date stated above, at **1:20 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) **RENAL SHUT DOWN** INTERVAL BETWEEN ONSET AND DEATH **2 DAYS**

(b) **LT. MID THIGH AMPUTATION** **2 DAYS**

(c) **EMBOLUS TO LT. LOW. LEG** **2-3 WKS**

OTHER SIGNIFICANT CONDITIONS **GENERALIZED ARTERIOSCLEROSIS** **YRS**

Was autopsy performed? **YES**

What test confirmed diagnosis? **PHYSICAL EXAM. LAB. TESTS**

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

(Signature) **Carey M. Peters**, M. D.
CAREY M. PETERS
(Print or Type Name)

(Address) **110 FRANCIS ST Boston** Date **1 FEB 1967**

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

DATE OF BURIAL **February 3, 1967**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St. Winthrop, Mass.**

Received and filed **FEB 7 1967**

J. J. Kane
(Registrar)

A TRUE COPY ATTEST:

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 **Adelaide Walker**
(Give maiden name of wife in full)

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

12 AGE **93** Years **4** Months **13** Days If under 24 hours
Hours.....Minutes

13 Usual Occupation **retired banker**
(Kind of work done during most of working life)

14 Industry or Business **general banking**

15 Social Security No. **021-01-3815**

16 BIRTHPLACE (City) **Medfield**
(State or country) **Massachusetts**

17 NAME OF FATHER **Edwin Whittemore**

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

19 MAIDEN NAME OF MOTHER **Anna Elizabeth Cleveland**

20 BIRTHPLACE OF MOTHER (City) **Walpole**
(State or country) **Massachusetts**

21 Informant **Mrs. Norman W. Davis**
(Address) **85 Bartlett Rd. Winthrop**

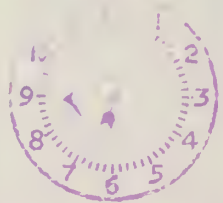
I HEREBY CERTIFY that a satisfactory standard certificate of death
has been filed with me BEFORE the burial or transit permit was issued:
Seipen H. Zonard **505411**
(Signature of Agent of Board of Health or other)

Feb 3 1967
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

MAR 21 '67 AM



CLERK
MASS.

The Commonwealth of Massachusetts

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

(City or town where this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 47

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

Essex
(County)Danvers
(Town)

Danvers State Hosp.

2 FULL NAME Harold Shifman

(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. 68 Locust St.

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 21 10 6 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 6 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
April 30 61 February 6 67
in alive on February 6 67
I last saw him alive on February 6 67, death is said to
have occurred on the date stated above, 11:25 pm

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Infarction

Mins.

(b) Due To Coronary Occlusion

Mins.

(c) Due To

OTHER
SIGNIFICANT
CONDITIONS

No

Was autopsy performed? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) Willard M. Hausman, M. D.
Dr. Willard M Hausman

(Address) Hathorne, Mass 2/6 67

6 Share Tefila Cemetery W. Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 7 67

7 NAME OF FUNERAL DIRECTOR Levine Chapel
Brookline Mass.

ADDRESS

Received and filed Feb. 10 MAR 23 1967

(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 (Give maiden name of wife in full)

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

52 0 22 AGE Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business: not determined

15 Social Security No. Boston

16 BIRTHPLACE (City) Massachusetts
(State or country)

17 NAME OF FATHER Benjamin Shifman

18 BIRTHPLACE OF FATHER (City) Not determined
(State or country) Russia

19 MAIDEN NAME OF MOTHER Evelyn Lakin

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

21 Informant Helen A Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

Tracy I Flagg

Dir. of Public Health

DATE FILED 2/17/67

MARGIN RESERVED FOR BINDING
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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSAFFIDAVIT AND CORRECTION
OF A RECORD OF DEATH

BOSTON#20

48

(City or town making return)

01284

Registered No.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. **Beth Israel Hospital** St., Ward }(If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME **Ruth Kearney (Hill)**

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

(If U. S.
War Veteran,
specify WAR)(a) Residence, No. **876 Shirley**

(Usual place of abode)

St. **Winthrop, Mass.**

(If nonresident give city or town and state)

Length of stay: In hospital or institution

(Specify whether)

years months days. In this community yrs. mos. days.

10

36

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR 5 SINGLE (write the word)

FEMALE WHITE

MARRIED
WIDOWED
or DIVORCED

MARRIED

6 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

or) WIFE of **John H. Kearney**

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AG 46 Years Months Days If less than 1 day
Usual Hours Minutes9 Occupation: **Tel Operator**Industry
0 or Business: **N.E. Tel. & Tel.**

1 Social Security No.

2 BIRTHPLACE (City) **East Boston**
(State or country) **Mass**13 NAME OF
FATHER **Frederick Hill**14 BIRTHPLACE OF
FATHER (City) **E. Boston**
(State or country) **Mass**15 MAIDEN NAME
OF MOTHER **Mary E Cahill**16 BIRTHPLACE OF
MOTHER (City) **E. Boston**
(State or country) **Mass**Informant. **John H. Kearney** ()
(Address) **876 Shirley St., Winthrop, Mass.**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF
DEATH **Feb 7 1967**
(Month) (Day) (Year)19 I HEREBY CERTIFY, That I attended deceased from
Jan 27 1967, Feb 7 1967I last saw her alive on **Feb 7 1967**, death is said
to have occurred on the date stated above, **1:15A** m. Duration

Immediate cause of death

Hepatitis and Cirrhosis**Uremia**Due **Peritonitis****Fracture, left ankle**

Due to

Other conditions
(Include pregnancy within 3 months of death)

Physician

Major findings:
Of operationsUnderline
the cause to
which death
should be
charged sta-
tistically.

Date of

Of autopsy **No**

What test confirmed diagnosis?

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

If so, specify

(Signed) **Abraham Ginsburg,** M. D.
(Address) **330 Brookline Ave 3/8 1967**Place of Burial or Removal (City or town) **Winthrop**DATE OF BURIAL **Feb 10 1967**22 NAME OF
FUNERAL DIRECTOR **Maurice W. Kirby**
ADDRESS **210 Winthrop St., Winthrop**Received and filed **Feb 13 1967** 19

A TRUE COPY ATTEST:

(Registrar)

DEPOSITION

WRITE LEGIBLY WITH DURABLE BLACK INK

The Commonwealth of Massachusetts }
County of **Suffolk** } ss.:

The undersigned, being duly sworn, depose and say that the record relating to the death of **Ruth Kearney** in the **city** of **Boston**,
(Give name of decedent exactly as recorded on the original record) (City or town) (Name of city or town)
does not fully and correctly state all the facts relating to said death, and that the true statement of facts omitted or incorrectly stated in said record has been supplied by.....**him**.....on the
(Him or her)
form of certificate on the other side of this blank.

SIGNATURE	RESIDENCE (City or town, street and number, if any)	Relation to decedent, if any
Abraham Ginsburg	200 Brookline St., Newton	Attending Physician

FURTHER, The written evidence submitted to substantiate the affidavit was:

Attending Physician's medical report shown to correct cause of death.

Date, **March 8, 1967**

JAN 14 '69 AM
Then personally appeared before me the person whose signature appear above and made
oath that the statements subscribed to by **him** are true.

Name **Martha M. Goldrick**
N.P.
Official designation
(City or town clerk or assistant clerk)

FILED IN

John A. Clark

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. 01284

No. Beth Israel Hospital

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

NAME

Ruth Kearney (HILL)

PHYSICIAN — IMPORTANT

(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

Permanent Residence. No.

876 Shirley St

St. Winthrop, Mass.

(City or town and State)

stay: In place of death... years... months 10 days. In place of residence 3 1/2 years... months... days.

MEDICAL CERTIFICATE OF DEATH

OF February 7 1967
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from

27 Feb 1967 to Feb 7 1967

or alive on Feb 7 1967 death is said to

occur on the date stated above, at 1:15 A.M.

WAS CAUSED BY: IMMEDIATE CAUSE

Alcoholic Cirrhosis

Alcoholic Hepatitis

Renal Failure

a) Hepatitis and Cirrhosis

b) Uremia Peritonitis, Fracture

c) Left Ankle

Autopsy performed?

No

Most confirmed diagnosis?

Disease or injury in any way related to occupation of deceased?

Specify: Abrasion on Shin

c) Anthony Robbins, M.D.

ANTHONY ROBBINS

(Print or Type Name)

330 Brookline Ave Feb 7 1967

WINTHROP WINTHROP

of Burial or Cremation

(City or Town)

OF BURIAL FEB 10 1967

E OF RAL DIRECTOR MAURICE W. MURPHY

210 WINTHROP ST

WINTHROP MASS

d and filed

FEB 13 1967

Lillian J. Kane

(Registrar)

JE COPY ATTEST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

FEMALE WHITE

MARRIED
WIDOWED
DIVORCED
UNKNOWN

MARRIED

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

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

12

AGE

46

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

TEL OPERATOR

(Kind of work done during most of working life)

14 Industry

or Business

N.E. TEL & TEL

15 Social Security No.

16 BIRTHPLACE (City)

EAST BOSTON

(State or country) MASS

17 NAME OF

FATHER

FREDERICK HILL

18 BIRTHPLACE OF

FATHER (City)

EAST BOSTON

(State or country)

MASS

19 MAIDEN NAME

OF MOTHER

MARY E CAHILL

20 BIRTHPLACE OF

MOTHER (City)

EAST BOSTON

(State or country)

MASS

21 Informant JOHN H. KEARNEY

(Address)

876 SHIRLEY 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)

EOJ679

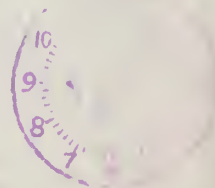
(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

MAR 21 11 AM



JFF:CL

W:

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE 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 fully 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.

100M-5-64-938000

FORM R-303

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

PLACE OF DEATH

SUFFOLK

(County)
BOSTON

(City or Town)

En route to East Boston Relief Station Hospital

No.

St.

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

2 FULL NAME

SALVATORE

(First Name)

(Middle Name)

PISCITELLI

(Last Name)

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

(a) Permanent Residence. No.

84 Banks Street,

St.

Winthrop

City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 7, 1967
(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 pulmonary edema.

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. Longo, M.D.

(Print or Type Name)

(Address) Boston Date 2/7 1967

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

DATE OF BURIAL February 10 1967

8 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St. East Boston, Mass.

Received and filed February 10 1967

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

Registered No. 01236

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

9 SEX

male

10 COLOR

white

11 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

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

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

13 AGE 72 Year Months Days
If under 24 hours Hours Minute

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

15 Industry or Business: *****

16 Social Security No.

17 BIRTHPLACE (City) State or country) Italy

18 NAME OF FATHER

Pasquale Piscitelli

19 BIRTHPLACE OF FATHER (City)

(State or country) Italy

20 MAIDEN NAME OF MOTHER Sabina Caporale

21 BIRTHPLACE OF MOTHER (City)

(State or country) Italy

22 Informant (Address) Lucia Piscitelli (wife)
84 Banks St., Winthrop, Mass.

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

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane
City Registrar

MAR 21 '67 AM



A TRUE COPY ATTEST:

William J. Kane.
City Registrar

MAR 21 '67 AM



FORM R-301

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 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).

The Commonwealth of Massachusetts

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

(City or Town making this return)

51

PLACE OF DEATH

Suffolk
(County)Boston
(City or Town)

No. 108 Jersey St.,

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

Registered No.

01652

2 FULL NAME

RUTH B. MACPHERSON

(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. 33 Orlando Ave.,

St. Winthrop Mass

(City or town and State)

Length of stay: In place of death.....years.....months.....5.....days. In place of residence.....50.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEBRUARY 17, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
VIEWED to Body
I last saw him alive on 19....., death is said to
have occurred on the date stated above, at m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL INFARCTION

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

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

If so, specify

(Signature) Pasquale R. Tereschi, M. D.

PASQUALE R. TERESCHI
(Print or Type Name)

(Address) Boston Health Dept. Date 17 Feb 1967

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

DATE OF BURIAL February 20, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed FEB 24 1967 19

William J. Waver

(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 Macpherson

(Husband's name in full)

12

AGE 61 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation Clerk

(Kind of work done during most of working life)

14 Industry

or Business: Newspaper Distributors

15 Social Security No.

16 BIRTHPLACE (City)

Boston

(State or country)

Mass

17 NAME OF

FATHER George F. Hesenius

18 BIRTHPLACE OF

FATHER (City) Salem

(State or country)

New Hampshire

19 MAIDEN NAME

OF MOTHER Mary E. Mulloy

20 BIRTHPLACE OF

MOTHER (City) Boston

(State or country)

Mass

21 Informant

Joseph A. MacPherson

(Address) 96 Haverhill St., No Reading

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

J. J. Danagan

(Signature of Agent of Board of Health or other)

(Date of Issue of Permit)

Feb 19, 1967

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

MAR 2



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, (i. L.)

25M-3-61-930213

PLACE OF DEATH

MIDDLESEX
(County)

MEDFORD

(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

MEDFORD

(City or town making return)

Registered No. 52

No. Lawrence Memorial Hospital

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

2 FULL NAME Richard Carr

(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. 49 Prospect Ave.,
(Usual place of abode)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.....8.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 18, 1967
(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

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?

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

If so, specify

(Signed) s/Andrew D. Guthrie, M. D.

(Address) Medford, Mass. Date 2/18 1967

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

DATE OF BURIAL February 21, 1967

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St., Winthrop

Received and filed February 20 1967

(Registrar of City or Town where deceased resided) CITY CLERK

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 Mary (Noone) Carr
(Give maiden name of wife in full)

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

13 DATE OF BIRTH

14 AGE 39 Years.....Months.....Days If under 24 hours
Hours.....Minutes15 Usual Occupation: Truck Driver
(Kind of work done during most of working life)

16 Industry or Business: General Trucking

17 Social Security No. 033-16-7168

18 BIRTHPLACE (City) Everett, Mass.
(State or country)

19 NAME OF FATHER Francis J. Carr

20 BIRTHPLACE OF FATHER (City) Cambridge
(State or country) Mass.

21 MAIDEN NAME OF MOTHER Emily Melonson

22 BIRTHPLACE OF MOTHER Everett, Mass.
(State or country)23 Informant Mary A. Carr
(Address) 49 Prospect Ave., Winthrop

A TRUE COPY.

ATTEST: Joseph F. McLaughlin
(Registrar of City or Town where death occurred)

DATE FILED 19

u

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

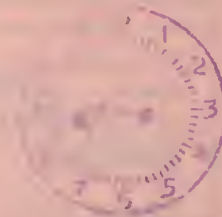
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

MAY 14 '67 AM



TOWN CLERK

WASS

VoTe
T.M.
Jae

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

(City or Town making this return)

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

Registered No. 1827

No. 17 Gladestone St.

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

PHYSICIAN — IMPORTANT

2 FULL NAME Eufrasia Anzalone
(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. 480 Pleasant

St. Winthrop

(City or town and State)

Length of stay: In place of death years 5 months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 21 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
OCTOBER, 1967 to FEBRUARY 21, 1967
I last saw her alive on FEBRUARY 20, 1967, death is said to
have occurred on the date stated above, at 5:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART DIS.

Due To GEN. AA ARTERIOSCLEROSIS

Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

PENILITY

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) D. Thomas Staffer M. D.

D. Thomas Staffer M. D.
(Print or Type Name)

(Address) 21 BREEZESIDE Date FEBRUARY 22, 1967

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

DATE OF BURIAL Feb. 24 1967

7 NAME OF FUNERAL DIRECTOR William E. Papi

ADDRESS Pearl St. Malden

Received and filed FEB 27 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 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 Adolph Anzalone
(Husband's name in full)12 AGE 84 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. Ch B. L.

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Luigi De Iorio

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

19 MAIDEN NAME OF MOTHER Giovannina Forte

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

21 Informant Nina D'Amore

(Address) 17 Gladestone St. E. Boston

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

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

NOTA

MAR 21 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

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 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).

CITY 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)

STANDARD
CERTIFICATE OF DEATH

Registered No. **C1796**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 **Helen S. 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)

(a) Permanent Residence. No. **129 Cliff Ave.,** **St. Winthrop, Mass.**

(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 **February 21 1967**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Feb. 18 1967 to **Feb. 21 1967**

last saw her alive on **Feb. 21 1967**, death is said to
have occurred on the date stated above, at **1.50 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **SUBARACHNOID HEMORRHAGE**

Due To **RUPTURED ANEURYSM OF LEFT**
(b) **POSTERIOR COMMUNICATING ARTERY**

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? **Yes**What test confirmed diagnosis? **Autopsy**

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

(Signature) **Charles L. Clay, M.D.**, M. D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) **Ass't. Dir., Mass. Gen'l. Hosp.** Date **Feb. 21 1967**

6 **OLD FATHER ISRAEL EVERETT**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **FEBRUARY 22, 1967**

7 NAME OF FUNERAL DIRECTOR **TORF FUNERAL SERVICE**

ADDRESS **21 WASHINGTON ST. CHELSEA**Received and filed **FEB 21 1967**

A TRUE COPY ATTEST

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of **GILBERT RUBIN**
(Husband's name in full)

12 AGE **80** 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. **023-10-6105**

16 BIRTHPLACE (City) **SALEM MASS**
(State or country)

17 NAME OF FATHER **MORRIS SHUMAN**

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

19 MAIDEN NAME OF MOTHER **MARGARET COLE**

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

21 Informant **SUMNER GOLDSTEIN**(Address) **12 PRESCOTT 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

MAR 21 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

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).

43870
X

Funeral Director
Please use only
BLACK Ink.

OUT OF TOWN
SUFFOLK

PLACE OF DEATH
1

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL



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

Boston 55
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 01991

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

PHYSICIAN — IMPORTANT

2 FULL NAME Ella Mason
(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. 7 Somerset Terrace St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months.....4 days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 22 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 18, 1967 to Feb. 22, 1967
I last saw him alive on Feb. 22, 1967 death is said to

have occurred on the date stated above, at 12.10 P.M.
DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

Due To Congestive heart failure weeks

(b) Complete heart block weeks

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes Autopsy

What test confirmed diagnosis?

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

If so, specify

(Signature) Charles L. Clay, M.D., M. D.

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 22, 1967

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

DATE OF BURIAL February 27, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed MAR 1 1967

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) single
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 76 Years 0 Months 4 Days If under 24 hours
Hours Minutes

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

14 Industry or Business Law offices

15 Social Security No.

16 BIRTHPLACE (City) England
(State or country)

17 NAME OF FATHER Frederick Mason

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

19 MAIDEN NAME OF MOTHER Virginia Allen

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

21 Informant Mrs. Marion H. Freeman

(Address) 8 Somerset Terrace, 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 Register

MAR 21 57 AM



LENK

MASS

Vote

FORM R-301

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 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).

Declined by Medical Examiner

Funeral Directors
Please use only
BLACK Ink.

00M-8-66-943275

OUT OF - TOWN

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. 01834

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

(a) Permanent Residence. No. 11 Revere Street, s. 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 February 23 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 23, 1967, to Feb. 23, 1967.

last saw him alive on Feb. 23, 1967 death is said to

have occurred on the date stated above, at 3.55 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive and Arteriosclerotic Heart Disease 4 yrs

Due To Hypertension 8 yrs

(b)

(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

(Signature) Charles L. Cloy, M.D., M. D.

Charles L. Cloy, M.D.
(Print or Type Name)

(Address) Ass'n Dir., Mass. Gen'l. Hosp. Date Feb. 23, 1967

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

DATE OF BURIAL February 25 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed

William J. Kane
(Registrar)

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 James T. Reardon
(Husband's name in full)

12 AGE 71 Years Months Days If under 24 hours
Hours Minutes

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

14 Industry or Business Railroad

15 Social Security No. 16 BIRTHPLACE (City) East Boston, Mass.
(State or country)

17 NAME OF FATHER Peter Christopher

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

19 MAIDEN NAME OF MOTHER Bridget Fitzgibbons

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

21 Informant Dorothy Corbett

(Address) 79 Pleasant 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:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane
City Recorder

MAR 21 '67 AM



WINTHROP MASS.

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

(City or Town making this return)

57

STANDARD
CERTIFICATE OF DEATH

Registered No. 02059

OUT - OF - TOWN
Suffolk
(County)
Boston
(City or Town)



No. New England Medical Center Hospitals St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Harold Katz
(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. 92 Nahant Avenue St. Winthrop, Massachusetts
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 28 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from February 17, 1967, to February 28, 1967.

I last saw him live on February 28, 1967, death is said to have occurred on the date stated above, at 5:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Failure

(b) Due To Cardiomyopathy etiology?

(c) Due To Scleroderma

INTERVAL BETWEEN ONSET AND DEATH 6 mos

OTHER SIGNIFICANT CONDITIONS Tissue Calcinosi

Was autopsy performed? No
What test confirmed diagnosis? Clinical Evaluation

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

(Signature) Jerome Hartman MD, M. D.
(Print or Type Name) Jerome Hartman MD
(Address) New England Center Hosp Date 2/28 1967

6 PLACE OF BURIAL OR CREMATION Tifereth Israel - EVERETT
(City or Town)

DATE OF BURIAL March 1 1967

7 NAME OF FUNERAL DIRECTOR ROBERT LEVINE

ADDRESS 1668 Beacon St. Bkline

Received and filed MAR 3 1967

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 BARBARA KAPLAN
(Give maiden name of wife in full)

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

12 AG 50 Years 2 Months 8 Days If under 24 hours Hours Minutes

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

14 Industry or Business SELF EMPLOYED

15 Social Security No.

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

17 NAME OF FATHER MAX KATZ

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

19 MAIDEN NAME OF MOTHER MARY LEVINE

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

21 Informant Mrs. BARBARA KATZ
(Address) 92 Nahant Ave Winthrop

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

Official Designation March 1 - 1967 (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 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).

450-1
481
X70

SE COPY ATTEST:

William J. Kane.
City Registrar

MAR



OFFICE OF
WINT

and for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

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

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

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

conditions contrib-
uted to death but not
do 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)

STANDARD
CERTIFICATE OF DEATH

Registered No. 58

PLACE OF DEATH

Suffolk

(County)

Winthrop

(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 Catherine Marden (nee Twomey)

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

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

(a) Residence. No. 112 Chestnut St., North Reading

(Usual place of abode)

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 1, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

July 19, 62 to MARCH 1, 1967
I last saw him alive on FEB 27, 1967, death is said to

have occurred on the date stated above, at 10:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral arteriosclerosis

INTERVAL
BETWEEN
ONSET AND
DEATH

5 yrs

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? NO
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS Date 3/1/1967

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

DATE OF BURIAL March 4, 1967

7 NAME OF FUNERAL DIRECTOR Murray & Murray

Beach Street

ADDRESS Revere, Mass.

Received and filed MAR 3 1967

John A. Clark

(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 Albert Marden (Husband's name in full)

12 AGE 37 Years Months Days 13 Usual Occupation housewife If under 24 hours Hours Minutes

14 Industry or Business at home

15 Social Security No.

16 BIRTHPLACE (City) Ireland (State or country)

17 NAME OF FATHER John Twomey

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

19 MAIDEN NAME OF MOTHER c/o/1

20 BIRTHPLACE OF MOTHER (City) c/o/1 (State or country)

21 Informant Robert Campbell

(Address) 112 Chestnut St., No. Reading

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

Philip J. Vetrone

(Signature of Agent of Board of Health or other)

Dir. of Public Health Mar 3, 1967
(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

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

59

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

Viking Nursing Home

No. 142 Pleasant St., Winthrop

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

Registered No.

PHYSICIAN — IMPORTANT

2 FULL NAME Hattie B. Nagle (Frazier)
(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. 90 Lincoln Street St. Winthrop

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 6 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Feb. 6 1966, to March 6 1967I last saw him alive on March 5, 1967, death is said to
have occurred on the date stated above, at 1:15 am.DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Arteriosclerotic Heart
disease

(a) 1 yr.

(b) Generalized arterio-
sclerosis 3 yrs(c) Bilateral thrombo-
phlebitis 10 mosOTHER
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)(Address) 73 Bartlett Rd. 3-6 1967
Winthrop, Mass.6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 9th 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed MAR 6 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 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 Horace L. Nagle
(Husband's name in full)12 AGE 78 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business At home

15 Social Security No. 034-16-4840

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

17 NAME OF FATHER Samuel Frazier

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

19 MAIDEN NAME OF MOTHER Jane DeCoste

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

21 Informant Edward J. Nagle-Son

(Address) 22 Penfield Circle, Wakefield

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip S. Vitagliano (S)
Signature of Agent of Board of Health (or other)Sur. of Public Health March 6, 1967
(Official Designation) (Date of Issue of Permit)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).

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.

SUFFOLK

(County)

WINTHROP

(City or Town)



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

WINTHROP

(City or Town making this return)

60

STANDARD
CERTIFICATE OF DEATH

Registered No.

nd for burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
E OR CAUSES
F DEATH

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

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

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

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

PLACE OF DEATH

VIKING NURSING HOME

No.

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

PHYSICIAN — IMPORTANT

U.I. NAME

HORACE TOWNSEND

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

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

(a) Re No. APT. C9 VIKING GARDENS St. WINTHROP, MASS.
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 7 1967
(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

INTERVAL
BETWEEN
ONSET AND
DEATH

(a) Death presumably due to
natural causes

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? No
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 3/7/1967

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

DATE OF BURIAL MARCH 9 1967

7 NAME OF FUNERAL DIRECTOR ERNEST P. CAGGIANO

ADDRESS 147 WINTHROP ST. WINTHROP

Received and filed MAR 9 1967

(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
HUSBAND of EMMA MITCHELL
(Give maiden name of wife in full)

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

12 AGE 77 Years 4 Months 21 Days If under 24 hours
Hours.....Minutes

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

14 Industry or Business LEVER BROTHERS

15 Social Security No. 012-10-6139

16 BIRTHPLACE (City) ROBINSON, MAINE
(State or country)

17 NAME OF FATHER DUNCAN TOWNSEND

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

19 MAIDEN NAME OF MOTHER UNKNOWN

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

EMMA TOWNSEND

21 Informant APT C9 VIKING GARDENS
(Address) WINTHROP, MASS.

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

Philip G. Vitagliano Jr.
(Signature of Agent of Health or other)

Sir of Public Health 3/9/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... OCTOBER 4 1917

DATE OF DISCHARGE..... JANUARY 18 1919

RANK, RATING..... PRIVATE

ORGANIZATION AND OUTFIT..... SUPPLY CO. 301st FIELDARTILLERY

SERVICE NUMBER..... 1663357

.....

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.

To 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.

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,
§ 48.

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

100A-9-53-936348

PLACE OF DEATH

Suffolk
(County)
Boston
(City or Town)



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

(City or Town making this return)

Registered No. 02337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. Boston City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME Ernest Anderson (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence. No. 5 Twin St. Winthrop (If nonresident, give city or town and State)
Length of stay: In place of death 10 years 10 months 10 days. In place of residence 10 years 10 months 10 days.

MEDICAL CERTIFICATE OF DEATH			PERSONAL AND STATISTICAL PARTICULARS		
3 DATE OF DEATH <u>March 10 1967</u> (Month) (Day) (Year)	9 SEX <u>male</u>	10 COLOR <u>white</u>	11 SINGLE (write the word) MARRIED <u>married</u> WIDOWED DIVORCED UNKNOWN		
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.) <u>Fracture of skull and leg -</u> <u>Meningitis - Auto-accident</u> <u>Pedestrian - Boston 3-2-67</u>			12 If married, widowed, or divorced HUSBAND of <u>Elizabeth Veronica (O'Sear)</u> (Give maiden name of wife in full) (or) WIFE of _____ (Husband's name in full)		
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? <u>YES</u>			13 AGE <u>65</u> Years _____ Months _____ Days _____ If under 24 hours _____ Hours _____ Minutes _____ 14 Usual Occupation: <u>maintenance man</u> (Kind of work done during most of working life) 15 Industry or Business: <u>Carl Hendrick Com. (Lights)</u> 16 Social Security No. <u>not known</u> 17 BIRTHPLACE (City) <u>Sweden</u> (State or country)		
6 Was disease or injury in any way related to occupation of deceased? If so, specify _____ (Signed) <u>Richard Ford M.D.</u> (Print of true Name) <u>Boston Mass.</u> Date <u>3-11-67</u> (Address) <u>Winthrop Cem. Winthrop</u> 7 <u>Winthrop Cem. Winthrop</u> Place of Burial or Cremation (City or Town) DATE OF BURIAL <u>March 15, 1967</u>			18 NAME OF FATHER <u>John Anderson</u> 19 BIRTHPLACE OF FATHER (City) <u>Sweden</u> (State or country) 20 MAIDEN NAME OF MOTHER <u>not known</u> 21 BIRTHPLACE OF MOTHER (City) <u>Sweden</u> (State or country)		
8 NAME OF FUNERAL DIRECTOR <u>Maurice W. Kirby</u> ADDRESS <u>210 Winthrop St. Winthrop</u> Received and filed <u>March 14 1967</u> A TRUE COPY ATTEST: _____ (Registrar)			22 Informant (Address) <u>Elizabeth Anderson</u> <u>5 Twin St. Winthrop. Mass.</u> I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: <u>Eugene Honora F. 06854</u> (Signature of Agent of Board of Health or other) <u>March 12 1967</u> (Official Designation) (Date of Issue of Permit)		

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

MAR



OFFICE OF

WINTER

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.

FORM R-301

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).

The Commonwealth of Massachusetts		KEVIN H. WHITE SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS	WINTHROP (City or Town making this return)
1	SUFFOLK (County)	STANDARD CERTIFICATE OF DEATH	
	WINTHROP (City or Town)	Registered No. 63	
No. WINTHROP COMMUNITY HOSPITAL		{(If death occurred in a hospital or institution, St. give its NAME instead of street and number)	
2	FULL NAME JAMES R. H. LOWSON (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 WARI) W.W.2	
(a) Permanent Residence. No. 160 QUINCY AVENUE., St. WINTHROP, MASS. (City or town and State)			
Length of stay: In place of death.....years 2 months 10 days. In place of residence 20 years.....months.....days.			
MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3	DATE OF DEATH MARCH 11 1967 (Month) (Day) (Year)	8 SEX male	9 COLOR white
4	I HEREBY CERTIFY, That I attended deceased from JAN. 1960 to MARCH 11, 1967 I last saw him alive on MARCH 10, 1967, death is said to have occurred on the date stated above, at 4:00 a.m.	10 SINGLE (write the word) MARRIED married WIDOWED DIVORCED UNKNOWN	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE		11 If married, widowed, or divorced HUSBAND of Norma Lavern Robinson (Give maiden name of wife in full)	
(a) Cerebrovascular Occlusion	INTERVAL BETWEEN ONSET AND DEATH 3 mos.	(or) WIFE of (Husband's name in full)	
(b) and ARTERIO SCLEROTIC HEART DISEASE	10 yrs.	12 AGE 55 Years 0 Months 6 Days	If under 24 hours Hours Minutes
(c) Generalized ARTERIO SCLEROSIS	10 yrs.	13 Usual Occupation Branch Officer (Kind of work done during most of working life)	
OTHER SIGNIFICANT CONDITIONS None		14 Industry or Business First National Bank	
Was autopsy performed? No		15 Social Security No. 020-14-3539	
What test confirmed diagnosis? Clinical		16 BIRTHPLACE (City) Boston (State or country) Massachusetts	
5 Was disease or injury in any way related to occupation of deceased? No If so, specify		17 NAME OF FATHER David Stewart Lowson	
(Signature) Charles Liberman, M. D. CHARLES LIBERMAN (Print or Type Name)		18 BIRTHPLACE OF FATHER (City) Scotland (State or country)	
(Address) WINTHROP, MASS. Date 3/11/1967		19 MAIDEN NAME OF MOTHER Mary Elizabeth Harrow	
6 Winthrop Cemetery, Winthrop, Mass. Place of Burial or Cremation (City or Town)		20 BIRTHPLACE OF MOTHER (City) Scotland (State or country)	
DATE OF BURIAL March 14, 1967		21 Informant Mrs. James R. H. Lowson (Address) 160 Quincy Avenue, Winthrop	
7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Philip G. Vito-Glump (Signature of Agent of Board of Health or other) Dir. of Public Health 3/14/67 (Official Designation) (Date of Issue of Permit)	
ADDRESS 174 Winthrop St. Winthrop			
Received and filed MAR 14 1967			
A TRUE COPY ATTEST:	(Registrar)		

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....23 June 42.....

DATE OF DISCHARGE.....4 Jan. 46.....

RANK, RATINGT/Sgt.....

ORGANIZATION AND OUTFIT.....4108th. AAF Base Unit.....

SERVICE NUMBER.....11 053 968.....

.....

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.

FORM R-301

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,
asthema, 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).

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. 61

PLACE OF DEATH
1 SUFFOLK
(County)
WINTHROP
(City or Town)
No. Winthrop Community Hospital

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

2 FULL NAME Dr. Frederick Stone
(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. 11 Bellevue Ave., St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death, 12 years, months, 12 days. In place of residence, 60 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 12 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec to March 12 1967
I last saw him alive on March 11, 1967 death is said to
have occurred on the date stated above, at 5 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral vascular accident

Due To (b) arteriosclerosis

Due To (c)

OTHER SIGNIFICANT CONDITIONS Congestive heart failure
Carcinoma 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) H. B. Greenfield, M. D.

(Address) Winthrop, Mass. Date March 12 1967

6 Woodlawn Crematory Everett
Place of Burial or Cremation March 15 67
DATE OF BURIAL 19

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed MAR 14 1967 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

12 AGE 89 Years 2 Months 3 Days If under 24 hours
Hours Minutes

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

14 Industry or Business Private office

15 Social Security No. 028-30-3491

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

17 NAME OF FATHER Samuel Stone

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

19 MAIDEN NAME OF MOTHER Susan Reed

20 BIRTHPLACE OF MOTHER (City) Greenville
(State or country) Connecticut

21 Informant Harriet Grace Stone

(Address) 11 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:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Sup. of Public Health 3/14/67
(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.

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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.

FORM R-301

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

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

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

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

nditions contrib-
o death but not
e to the terminal
condition given

PLACE OF DEATH

Suffolk

Winthrop



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

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 65

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

2 FULL NAME EUGENE H. McLAUGHLIN
(If deceased was married, give name of wife; if single, give maiden name.)

PHYSICIAN — IMPORTANT

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

(a) Permanent Residence, No. 239 Winthrop Shore Drive
(Usual place of abode)

Winthrop
(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 14, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
MARCH 14, 1966 to MARCH 14, 1967
I last saw him on MARCH 8, 1967, death is said to
have occurred on the date stated above, at 6:20 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular(b) occlusion(c) Cerebral ARTERIOSCLEROSISOTHER SIGNIFICANT CONDITIONS Parkinson'sWas 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) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 3/14/67

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 17, 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS 210 Winthrop St. Winthrop

Received and filed MAR 16 1967 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 VERA C. LEVERONI
(Give maiden name of wife in full)

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

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

13 Usual Occupation MED. DEPT. U.S. VET. ADM.
(Kind of work done during most of working life)

14 Industry
or Business

15 Social Security No. 012-07-7171

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS.

17 NAME OF FATHER MICHAEL F. McLAUGHLIN

18 BIRTHPLACE OF FATHER (City) EAST BOSTON
(State or country) MASS.

19 MAIDEN NAME OF MOTHER JULIE E. BUCKLEY
IRELAND

20 BIRTHPLACE OF MOTHER (City) MRS. FRANCES McLAUGHLIN
(State or country) IRELAND

21 Informant MISS FRANCES McLAUGHLIN
(Address) 239 Shore Drive Winthrop

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

Whitely S. Delaghaus
(Signature of Agent of Board of Health or other)
Dir. of Public Health - March 16, 1967
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE MAY 29, 1918

DATE OF DISCHARGE APRIL 23 1919 MUS 2C

RANK, RATING MUS 2C

ORGANIZATION AND OUTFIT USN RF

SERVICE NUMBER 27291

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.

FORM R-301

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 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).

PLACE OF DEATH

SUFFOLK
(County)
WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

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

2 FULL NAME JOSEPH NE A (BRESNAHAN) CONNORS

(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. 124 CRESCENT AVE. St. REVERE MASS

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 15 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from June 5 to March 15 1967

I last saw him alive on March 14, 1967, death is said to have occurred on the date stated above, at 7:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage 2/18/67

(b) 1st stroke 10/21/66 9/15

(c) Senility 1/1/67 9/15

OTHER SIGNIFICANT CONDITIONS 1st stroke 10/21/66 9/15

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 Ne A Connors, M. D.

(Print or Type Name) Joseph Ne A Connors

(Address) 194 Washington St. Date 3-15-1967

6 Holyhood Brookline

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 17, 1967. 19.

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave., Revere

Received and filed MAR 20 1967 19.

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. 66

(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)

(a) Permanent Residence. No. 124 CRESCENT AVE. St. REVERE MASS

(City or town and State)

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

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 Timothy J. Connors

(Husband's name in full)

12 AGE 84 Years 7 Months 14 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) Londonberry N.H.

(State or country)

17 NAME OF FATHER William H. Bresnahan

18 BIRTHPLACE OF FATHER (City) Ireland

(State or country)

19 MAIDEN NAME OF MOTHER Ellen Haggerty

20 BIRTHPLACE OF MOTHER (City) Boston

(State or country) Mass.

21 Informant Timothy J. Connors

(Address) 10 Deerfield Rd., Norwood

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

Philip J. O'Donoghue

(Signature of Agent of Board of Health or other)

Dir. of Public Health, March 16, 1967

(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

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FORM R-301

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

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MEDICAL CERTIFICATE

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OF DEATH

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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).

Med-examiner notified - referred to attending physician.

Pos To 4-7-67
SUFFOLK
(County)
WINTHROP, MASS.
(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 FULL NAME MISS. ANNA M. DOYLE
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 31 Moore Street, East Boston St. 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 MARCH 16 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 1945, to MARCH, 1967.

I last saw him alive on MARCH 16, 1967, death is said to
have occurred on the date stated above, atm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

Due To (b) Hypertensive Arterio-

Due To (c) Sclerotic Heart Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical

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

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 3/16/1967

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

DATE OF BURIAL March 18, 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St. E. Boston

Received and filed MAR 20 1967 1967

A TRUE COPY ATTEST:

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. 67

(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
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 79 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: Boston Schools

15 Social Security No. 02-2-013-36-4142

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

17 NAME OF FATHER James Doyle

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

19 MAIDEN NAME OF MOTHER Nora O'Connor

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

21 Informant Miss Gertrude F. Doyle

(Address) 31 Moore 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:

Philip J. Vito
(Signature of Agent of Board of Health or other)

Dir. of Public Health 3/17/67
(Official Designation) (Date of Issue of Permit)

(Registrar)

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

RULES OF PRACTICE

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

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

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

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

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

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

FORM R-301

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	WINTHROP (City or Town making this return)
SUFFOLK (County)		STANDARD CERTIFICATE OF DEATH	
WINTHROP (City or Town)		Registered No. 63	
No. WINTHROP COMMUNITY HOSPITAL		(If death occurred in a hospital or institution, St. give its NAME instead of street and number)	
2 FULL NAME RALPH GENZALE (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) 2	
(a) Permanent Residence. No. 79 HOMER ST.		St. EAST BOSTON, MASS. (City or town and State)	
Length of stay: In place of death, 1 years, 1 months, 1 days. In place of residence, 25 years, 1 months, 1 days.			
MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH March 17 1967 (Month) (Day) (Year)		8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED married WIDOWED DIVORCED UNKNOWN	
4 I HEREBY CERTIFY That I attended deceased from Oct 1965, to March 17, 1967 I last saw him alive on March 16, 1967, death is said to have occurred on the date stated above, at 2:05 p.m.		11 If married, widowed, or divorced HUSBAND of Frances Guerra (Give maiden name of wife in full)	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage (b) Atherosclerosis - gen (c) Hypertension essential		(or) WIFE of (Husband's name in full)	
INTERVAL BETWEEN ONSET AND DEATH 4 hr		12 AGE 50 Years Months Days If under 24 hours Hours Minutes	
OTHER SIGNIFICANT CONDITIONS Myocardial Heart disease		13 Usual Occupation Police Officer (Kind of work done during most of working life)	
Was autopsy performed? What test confirmed diagnosis?		14 Industry or Business City of Boston, Division 15	
5 Was disease or injury in any way related to occupation of deceased? If so, specify		15 Social Security No. 022-01-5253	
(Signature) Joseph G. Rapino, M. D. Joseph G. RAPINO (Print or Type Name)		16 BIRTHPLACE (City) Boston, Mass. (State or country)	
(Address) 194 Woodlawn Cemetery, Everett Date 3-17-1967		17 NAME OF FATHER Augustino Genzale	
6 Place of Burial or Cremation Woodlawn Cemetery Everett March 20 1967		18 BIRTHPLACE OF FATHER (City) Italy (State or country)	
DATE OF BURIAL		19 MAIDEN NAME OF MOTHER Carmela Genzale (same)	
7 NAME OF FUNERAL DIRECTOR Vincent Rapino 9 Chelsea St., East Boston, Mass.		20 BIRTHPLACE OF MOTHER (City) Italy (State or country)	
ADDRESS		21 Informant Frances Genzale (wife) (Address) 79 Homer St., East Boston, Mass.	
Received and filed John A. Clark MAR 21 1967		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Philip G. Vitagliano (Signature of Agent of Board of Health or other) Dir. of Public Health 2/20/67 (Official Designation) (Date of Issue of Permit)	

A TRUE COPY ATTEST:

(Registrar)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE..... 1/12/43
DATE OF DISCHARGE..... 11/30/45
RANK, RATING..... Shipfitter first class
ORGANIZATION AND OUTFIT..... U.S. Navy
SERVICE NUMBER..... 202-86-98

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.



TOWN OF WINTHROP

OFFICE OF THE TOWN CLERK

Town Hall, 1 Metcalf Square, Winthrop, MA 02152 Telephone: 617-846-1742 Fax: 617-539-5814

Carla Vitale
Town Clerk

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. 60



PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 86 Sargent Street

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

(a) Permanent Residence. No. 86 Sargent Street St. Winthrop, Mass.
(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 March 17 1967
(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 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably
due to natural

Due To (b) causes:

Due To (c) causes:

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 3/18/1967

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

DATE OF BURIAL March 20, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 20 1967

(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 Harold Addison Ham
(Husband's name in full)

12 AGE 74 Years 4 Months 5 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. 025-36-7241

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

17 NAME OF FATHER Daniel Fowler

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

19 MAIDEN NAME OF MOTHER Annie Layte

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

21 Informant Harold A. Ham

(Address) 86 Sargent St. Winthrop

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

Philip S. Vitzthum (Signature of Agent of Board of Health or other)

Sw. of Public Health 3/20/67 (Date of Issue of Permit)

(Official Designation)

A TRUE COPY ATTEST:

FORM R-301

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. 69

No. 86 Sargent Street

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

PHYSICIAN — IMPORTANT

2 FULL NAME Helen Frances Ham(Fowler)
(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. 86 Sargent Street Winthrop, Mass.
(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 March 17 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....1 last saw h..... alive on....., 19....., death is said to
have occurred on the date stated above, at 6:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably
(b) due to natural
(c) causes.Due To
(c) causes.OTHER
SIGNIFICANT
CONDITIONSWinthrop 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 3/18/1967

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

DATE OF BURIAL March 20, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 20 1967 19

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 Harold Addison Ham
(Husband's name in full)12 AGE 74 Years 4 Months 5 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. 025-36-7241

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

17 NAME OF FATHER Daniel Fowler

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

19 MAIDEN NAME OF MOTHER Annie Layte

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

21 Informant Harold A. Ham

(Address) 86 Sargent St. Winthrop

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

Philip E. Vitzthum (3)

(Signature of Agent of Board of Health or other)

Sur. of Public Health 3/20/67

(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
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).

Reported to Med. Examiners Office - 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.

The Commonwealth of Massachusetts

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

Rowley

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 10 70

PLACE OF DEATH

Essex

(County)

Rowley

(City or Town)

No. Seaview Nursing Home

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

2 FULL NAME Herman Lincoln Waldo

(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. 110 Grovers Ave.

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 17, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
January, 1967, to March 17, 1967.
I last saw him alive on March 17, 1967, death is said to
have occurred on the date stated above, at 6:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Thrombosis

(b) Due To Arteriosclerosis

(c) Due To

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) Joseph R. LaPaglia, M. D.

(Address) Rowley, Mass. Date.....19.....

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

DATE OF BURIAL March 20, 1967

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

Received and filed MAR 29 1967

(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 62 Years 2 Months 11 Days If under 24 hours
Hours Minutes13 Usual Occupation: Retired
(Kind of work done during most of working life)14 Industry
or Business:

15 Social Security No. 012-03-1698

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

17 NAME OF FATHER John Waldo

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

19 MAIDEN NAME OF MOTHER Alice Maud

20 BIRTHPLACE OF MOTHER (City) Boston, Mass.
(State or country)21 Informant Frank Waldo
110 Grovers Ave., Winthrop, Mass.
(Address)

A TRUE COPY

ATTEST: Edward J. MacDonald
(Registrar of City or Town where death occurred)

DATE FILED March 17 1967

MARGIN RESERVED FOR BINDING
WRITE 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.)

WED 29 '67 AM

SPACE FOR ADDITIONAL INFORMATION

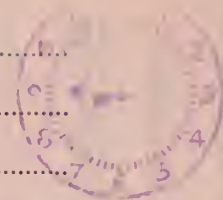
DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



FORM R-301

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. 191

No. 60 Faun Bar Ave., Winthrop

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

PHYSICIAN — IMPORTANT

2 FULL NAME JOHN CARNEY
(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. 60 Faun Bar Avenue 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 March 19, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from March 19, 1967, to March 19, 1967.
I last saw him alive on March 18, 1967, death is said to have occurred on the date stated above, at 3:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

(b) Cancer of Lung

(c) Due To

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? No

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

(Signature) Joseph E. McGee, M. D.

(Print or Type Name) Joseph E. McGee

(Address) 194 Washington Ave., Medford 1967

6 Oak Grove Medford
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 22, 1967

7 NAME OF FUNERAL DIRECTOR Frank H. Carr

ADDRESS 79 Elm St., Charlestown

Received and filed MAR 21 1967

John A. Carr (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed or divorced HUSBAND of Teresa McLaughlin
(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 Engineer (Ret.)
(Kind of work done during most of working life)

14 Industry or Business Boston Gas Company

15 Social Security No.

16 BIRTHPLACE (City) Donegal
(State or country) Ireland

17 NAME OF FATHER John Carney

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

19 MAIDEN NAME OF MOTHER Ellen (Carney) Carney

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

21 Informant Mrs. Teresa Carney

(Address) 60 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:

Philip E. McLaughlin (Signature of Agent of Board of Health or other)

Dir. of Public Health (Official Designation) 3/27/67 (Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

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).

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

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 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).

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. 12

1 PLACE OF DEATH
Suffolk
(County)
Winthrop
(City or Town)
No. 91 Bartlett Road

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

2 FULL NAME Arthur James Connelly
(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. 91 Bartlett Road St. Winthrop, Mass.
(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 19 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec 67, 1967, to March 19, 1967
I last saw him on 3-18-67, death is said to
have occurred on the date stated above, at 6:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure

(b) Rheumatic heart disease

(c)

OTHER
SIGNIFICANT
CONDITIONS

mitral stenosis

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 No

(Signature) H. B. Creedfield, M. D.
(Print or Type Name)
(Address) 447 Winthrop St. Winthrop, Mass. 3-21 1967

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

DATE OF BURIAL March 22, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed MAR 21 1967
John A. Clark

A TRUE COPY ATTEST:

(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 54 Years 6 Months 23 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: Retail Hardware Store

15 Social Security No. East Boston
16 BIRTHPLACE (City) Massachusetts

17 NAME OF FATHER James Henry Connelly

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

19 MAIDEN NAME OF MOTHER Annie Rachael Callahan

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

21 Informant Mrs. Frank E. Fraser

(Address) 63 Waldemar Avenue, Winthrop

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

Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)

Sir of Public Health 3/21/67
(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.

FORM R-301

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 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).

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, Mass

(City or Town)

No. Winthrop Community Hospital

STANDARD
CERTIFICATE OF DEATH

Registered No.

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

PHYSICIAN — IMPORTANT

2 FULL NAME Anita Fontaine (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. 16 Pearl Avenue

Winthrop, Mass

(City or town and State)

Length of stay: In place of death.....years.....months²⁴.....days. In place of residence.....50.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 19, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Sept 22, 1951, to MAR 19, 1967

I last saw her alive on MAR 19, 1967 death is said to
have occurred on the date stated above, at 12:05 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCT 12:05 P.M.

(b) DUE TO HYPERTENSIVE & ARTERIO-
SCLEROTIC HEART DIS 5 YRS

(c) DUE TO CONGESTIVE FAILURE 7 mo.

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., M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST. Date 3/19/67
WINTHROP MASS

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

DATE OF BURIAL MAR. 22, 1967

7 NAME OF FUNERAL DIRECTOR FREDERICK J. MAGRATH

ADDRESS East Boston

Received and filed MAR 21 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

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 ROBERT FONTAINE
(Husband's name in full)

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

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

14 Industry or Business: own Home

15 Social Security No. CNAL

16 BIRTHPLACE (City) East Boston MASS.
(State or country)

17 NAME OF FATHER Charles B. Kelly

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

19 MAIDEN NAME OF MOTHER MARY E. Kelly

20 BIRTHPLACE OF MOTHER (City) St. John
(State or country) NEW BRUNSWICK

21 Informant Ruth C. Kelly
(Address) 16 Pearl Ave. Winthrop

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

Philip A. Vitagliano (M.D.)
(Signature of Agent of Board of Health or other)

Director of Public Health 3/21/67
(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.

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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.

FORM R-301

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.

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Viking Nursing Home

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

2 FULL NAME

Leah Silverman

(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.

36 SUMMIT AVENUE

Viking Nursing Home

Winthrop, Mass

(City or town and State)

Length of stay: In place of death 2 years months days. In place of residence 33 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 21 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN 40 to MARCH 21 1967I last saw her alive on MARCH 20, 1967, death is said to
have occurred on the date stated above, at 8:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART

Due To DISEASE

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinico

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 3/22/1967

6 Forest Hills Crematory Boston

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 23 1967

7 NAME OF FUNERAL DIRECTOR Robert W. Levine

ADDRESS 1668 Beacon St. Brookline

Received and filed MAR 24 1967 19

A TRUE COPY ATTEST:

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 Casper Silverman

(Husband's name in full)

12

AGE 91

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)

Austria

17 NAME OF

FATHER

Samuel Schwartz

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Austria

19 MAIDEN NAME

OF MOTHER

Sarah (UNKNOWN)

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Austria

21 Informant

Mrs. Beatrice Carlson

(Address)

36 Summit Ave Winthrop

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

Charles P. Vachano

(Signature of Agent of Board of Health or other)

Dir of Public Health 3/22/67

(Official Designation)

(Date of Issue of Permit)

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

INSTRUCTIONS

FOR

MEDICAL CERTIFICATE

PRINT 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).

Registrar

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

RULES OF PRACTICE

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

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

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

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

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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.

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
disease, 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)

Bay View Nursing Home

No.

Ella Louise Jackson

2 FULL NAME

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

36 Bellevue Avenue

(a) Residence, No.

(Usual place of abode)

St.

Winthrop, Mass.

(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 26 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3/21/67, 19, to 3/26/67, 19, death is said to have occurred on the date stated above, at 9:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSARTERIOSCLEROTIC HEART
DISEASEINTERVAL
BETWEEN
ONSET AND
DEATH
5 Days

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 3/26/1967

6 Mt. Hope Cemetery, Boston, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 28, 1967

7 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons

495 Commonwealth Ave, Boston

ADDRESS

Received and filed

MAR 27 1967

(Registrar)

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. 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 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 Arthur Jackson

(Husband's name in full)

12 AGE 92 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 Own Home

15 Social Security No. None

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

17 NAME OF FATHER Charles A. Troup

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

19 MAIDEN NAME OF MOTHER Clara E. Wheeler

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

Mr. Carl Pratt

21 Informant 1377 Main St. Lynnfield, Mass.
(Address)

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

Philip G. Vtagliano

(Signature of Agent of Board of Health or other)

Div of Public Health 3/27/67

(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.

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. 76

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

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

(a) Residence. No. 10 Wave Way
(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 7 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 26 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JUNE 5, 1961 to MAR 26, 1967
I last saw him alive on MAR 26, 1967, death is said to
have occurred on the date stated above, at 12:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION 15 MIN

Due To (b) ARTERIO SCLEROTIC HEART DISEASE WITH CONGESTIVE

Due To (c) HEART FAILURE 6 YRS
HYPERTENSIVE 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.

MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 Pleasant St. Date 3/27/67
WINTHROP MASS

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

DATE OF BURIAL March 29, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 29 1967

John A. Clark (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 75 Years 1 Months 3 Days If under 24 hours
Hours Minutes

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

14 Industry or Business City of Boston

15 Social Security No. 02-4-0218

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

17 NAME OF FATHER John C. McGee

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

19 MAIDEN NAME OF MOTHER Agnes M. Ryder

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

21 Informant Julia J. McGee
10 Wave Way 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:

Ernest P. Caggiano (Signature of Agent of Board of Health or other)

Dir of Public Health 3/29/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... June 5, 1918

DATE OF DISCHARGE..... June 24, 1922

RANK, RATING Quartermaster 3/c

ORGANIZATION AND OUTFIT..... Navy

SERVICE NUMBER..... 132 94 62

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
disease, 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

WINTHROP

(City or Town making this return)

PLACE OF DEATH

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

Registered No. 6-10

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

2 FULL NAME ABRAHAM HOLZMAN (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. 300 Bryant St. St. Malden, 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, 45 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 28 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
3/22, 1967, to 3/28, 1967

I last saw him alive on 3/28, 1967. Death is said to
have occurred on the date stated above, at 2:5 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

(b) CARCINOMA OF PANCREAS

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH
5 mos

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? CHEMICAL & OPERATION

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

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

(Address) 222 Pleasant St. MAR 28 1967
WINTHROP MASS

6 Agudas Achim Cemetery Melrose
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 28, 1967

7 NAME OF FUNERAL DIRECTOR Murray Goldman

ADDRESS 174 Ferry St. Malden

Received and filed MAR 28 1967, 1967

John A. Clark
(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
HUSBAND of Ida White
(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 Sales - Auto Parts
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 023-01-8719

16 BIRTHPLACE (City) Pinsk
(State or country) Poland

17 NAME OF FATHER Samuel Holzman

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

19 MAIDEN NAME OF MOTHER Ann (Unknown)

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

21 Informant Harold Holzman
(Address) 26 Essex Road Milton

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

Philip A. Stokans (P)
(Signature of Agent of Board of Health or other)
Div. of Public Health 3/28/67
(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

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. 78

No. Viking Rest Home
Nursing(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)2 FULL NAME Ernest M Call

(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. 344 Western AveSt. Lynn Mass

(City or town and State)

Length of stay: In place of death 1 years 13 months 13 days. In place of residence 50 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 31 - 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from June 29, 1966, to March 31, 1967I last saw him live on March 30, 1967, death is said to have occurred on the date stated above, at 12:10 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease yrs.(b) arteriosclerosis yrs(c) maurice yrsOTHER SIGNIFICANT CONDITIONS maurice yrs

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 P. Grogan, M. D.(Print or Type Name) Joseph P. Grogan(Address) Joseph P. Grogan Date 3-31-676 Greenlawn Salem Mass
Place of Burial or Cremation (City or Town)DATE OF BURIAL April 4 19677 NAME OF FUNERAL DIRECTOR W.C/Goodrich
128 Washington St Lynn Mass

ADDRESS

Received and filed APR 3 1967 19John A. Clark
(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 Unable To Learn
(Give maiden name of wife in full)(or) WIFE of Unable To Learn
(Husband's name in full)12 AGE 82 10 7 If under 24 hours
Years Months Days Hours Minutes13 Usual Occupation Retired
(Kind of work done during most of working life)14 Industry or Business Employe Boston & Maine R.R.15 Social Security No 706-09-087616 BIRTHPLACE (City) Salem
(State or country) Mass17 NAME OF FATHER Mark Call18 BIRTHPLACE OF FATHER (City) Unable To Learn
(State or country) Unable To Learn19 MAIDEN NAME OF MOTHER Unable To Learn20 BIRTHPLACE OF MOTHER (City) Unable To Learn
(State or country) Unable To Learn21 Informant Division OF the Blind
39 Boylston St Boston Mass
(Address)

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

John A. Clark
Signature of Agent of Board of Health or otherJohn A. Clark
(Official Designation)7/3/67
(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.

MARGIN RESERVED FOR BINDING
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-5-611-938000

PLACE OF DEATH 1	Essex (County)				The Commonwealth of Massachusetts 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. 79					
No. Danvers State Hospital				(If death occurred in a hospital or institution, give its NAME instead of street and number)						
2 FULL NAME Joseph Terranova				(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. 274 Main St.				St. Winthrop, Mass				(City or town and State)		
Length of stay: In place of death 0 years 3 months 8 days.				In place of residence years months days.						
MEDICAL CERTIFICATE OF DEATH										
3 DATE OF DEATH March 13 1967										
(Month) (Day) (Year)										
4 I HEREBY CERTIFY, That I attended deceased from Dec. 5 66 to March 13 67										
I last saw alive on March 13 67, death is said to have occurred on the date stated above, at 11:00p.										
DEATH WAS CAUSED BY: IMMEDIATE CAUSE										
(a) Coronary Failure										
(b) Arteriosclerotic heart Dis. yrs.										
(c) Generalized Arteriosclerosis yrs.										
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. Dr. Willard M Hausman										
(Address) Hathorne, Mass. Date 3/13/ 67										
6 Winthrop Cemetery, Winthrop Place of Burial or Cremation (City or Town)										
DATE OF BURIAL March 17 67										
7 NAME OF FUNERAL DIRECTOR E. P. Caggiano										
ADDRESS Winthrop, Mass										
Received and filed March 16 67										
(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		Unknown		(Give maiden name of wife in full)						
(or) WIFE of		(Husband's name in full)								
12 AGE 90 0 25		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. 031-07-72-1-A										
16 BIRTHPLACE (City) Italy				(State or country)						
PARENTS	17 NAME OF FATHER Gaetano Terranova									
	18 BIRTHPLACE OF FATHER (City) Italy				(State or country)					
	19 MAIDEN NAME OF MOTHER Phyllipi Lunetta									
	20 BIRTHPLACE OF MOTHER (City) Italy				(State or country)					
21 Informant Helen A Ziolkowski				(Address) Danvers, Mass						
A TRUE COPY				Tracy I Flagg						
ATTEST: Dir. of Public Health				(Registrar of City or Town where death occurred)						
DATE FILED 3/14/67										

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

1947

19

FORM R-301

File 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 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

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 80

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 Sally (Baker) Schlafman
(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 Pico Ave

Winthrop

(City or town and State)

Length of stay: In place of death.....years.....months.....25days. In place of residence.....13years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 4 1 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
MAR 24 1967 to APRIL 1 1967
I last saw him alive on APRIL 1 1967 death is said to
have occurred on the date stated above, at 1:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

(b) CARCINOMA OF BREAST

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

2 YRS

7 YRS

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? PATHOLOGICAL & X-ray

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 OLESTON ST. Date 4/1/67

6 Children of Israel Haverhill
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 2, 1967

7 NAME OF FUNERAL DIRECTOR Edward M. Hymanson

ADDRESS Lynn, Mass.

Received and filed APR 4 1967

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 (Give maiden name of wife in full)

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

12 AGE 50 years 11 months 29 days
If under 24 hours
Hours Minutes

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

14 Industry or Business At Home

15 Social Security No. None

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

17 NAME OF FATHER Bamed Baker

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

19 MAIDEN NAME OF MOTHER Rose Gedansky

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

21 Informant Mark Schlafman-Son
(Address) 4 Pico Ave., Winthrop

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

(Signature of Agent of Board of Health or other)

(Official Designation) Div of Public Health 4/2/67
(Date of Issue of Permit)

50 Pleasant St.
more

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

10
8
7

1130

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

d for burial permit
Board of Health
its Agent.INSTRUCTIONS
FOR
CERTIFICATEOR TYPE
OR CAUSES
DEATHd 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 causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
the terminal
condition given

1 PLACE OF DEATH

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

Registered No. 81

No. 371 Winthrop St.

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

PHYSICIAN — IMPORTANT

2 FULL NAME John M. MacCormack
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, yes, was
if so specify WAR)(a) Permanent Residence, No.
(Usual place of abode)

371 Winthrop St

St. Winthrop Mass.
(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 April 2, 1967
(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 4:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) natural causes.

(c) 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
(Print or Type Name)

(Address) WINTHROP, MASS. Date 4/31 1967

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

DATE OF BURIAL April 5, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed APR 3 1967 19____

John A. Cleary
(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 76 Years. — Months. — Days If under 24 hours
Hours. — Minutes13 Usual Occupation Engineer
(Kind of work done during most of working life)

14 Industry or Business retired

15 Social Security No. 028-16-7294

16 BIRTHPLACE (City) Canada
(State or country)

17 NAME OF FATHER John M. MacCormack

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

19 MAIDEN NAME OF MOTHER Elezabeth (McLean)

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

21 Informant Mrs. Mary Atherton

(Address) 371 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:

Philip S. Vlachianopoulos

(Signature of Agent of Board of Health or other)

Director of Public Health 4/3/67

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Medical examiner notified - referred to Board of Health

SPACE FOR ADDITIONAL INFORMATION..... Feb 11, 1918
DATE OF ENTERING MILITARY SERVICE..... Feb 11, 1918
DATE OF DISCHARGE..... Sept. 30, 1921
RANK, RATING..... Engineer 1^c
ORGANIZATION AND OUTFIT..... USNR
SERVICE NUMBER..... 133-28-39

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.

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

WINTHROP

(City or Town making this return)

PLACE OF DEATH

SUSSEX

(County)

WINTHROP

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 82

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 Georgia A Cousins (Runnells)
(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. 6 Jesserson St. St. WINTHROP Mass.
(Usual place of abode) (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 3 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from May 1965 to April 3, 1967
I last saw him alive on April 3, 1967, death is said to have occurred on the date stated above, at 8:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

(b) Arterio sclerosis

(c) generalized

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 Gregoire, M. D.

(Address) 194 Elmwood St. W. W. 1967
(Print or Type Name) JOSEPH GREGOIRE

6 Church Yard Holderness N. H.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 4 1967

7 NAME OF FUNERAL DIRECTOR Ernest Plaggiano

ADDRESS 147 Wintthrop St Wintthrop

Received and filed APR 7 1967 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 ALVAH Cotton Cousins (Husband's name in full)

12 AGE 85 Years 9 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. 16 BIRTHPLACE (City) LYME
(State or country) New Hampshire

17 NAME OF FATHER J. POYNELLS

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

19 MAIDEN NAME OF MOTHER J.

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

21 Informant Mrs Esther McCollough
(Address) 66 Shore Dr WINTHROP Mass

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

Philip V. Tagliano
(Signature of Agent of Board of Health or other)

Sir of Public Health 4/7/67
(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

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. 82

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 — IMPORTANTINSTRUCTIONS
FOR
MEDICAL CERTIFICATE

2 FULL NAME Bucknam Paul C.

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

(Was deceased a WW1
U. S. War Veteran,
if so specify WAR)

(a) Permanent Residence. No. 6 Loring Rd. Winthrop Mass.

10 minutes

St. (City or town and State)

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

PRINT 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).

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 4, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
DEC. 15, 1952, to APRIL 4, 1967I last saw him alive on APRIL 4, 1967 death is said to
have occurred on the date stated above, at 8:10 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION

(b) Due To Arteriosclerotic & Hypertensive
Heart Disease

(c) Due To Generalized Arteriosclerosis

OTHER
SIGNIFICANT
CONDITIONS

NONE

Was autopsy performed? NO

What test confirmed diagnosis? Clinical & Laboratory

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

(Signature) M. Traubenstein M. D.

(Print or Type Name) M. TRAUBENSTEIN M. D.

(Address) 23 BARTLETT RD. Date April 4, 1967

Winthrop Winthrop

6 Place of Burial or Cremation April 7 (City or Town) 67

DATE OF BURIAL April 7, 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed APR 7 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN Married11 If married, widowed, or divorced
HUSBAND of Violet Hagman
(Give maiden name of wife in full)

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

12 AGE 67 Years 5 Months 6 Days If under 24 hours
Hours Minutes13 Usual Occupation Lighting engineer (retired)
(Kind of work done during most of working life)

14 Industry or Business Electric supply Co.

15 Social Security No. 010-07-7191

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

17 NAME OF FATHER Alonzo Bucknam

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

19 MAIDEN NAME OF MOTHER Addie Oliver

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

21 Informant Violet Bucknam

(Address) 6 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:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 3/30/17

DATE OF DISCHARGE..... 3/29/21

RANK, RATING Seaman

ORGANIZATION AND OUTFIT..... U S Navy

SERVICE NUMBER..... 1139300

.....

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

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

File for burial permit
with Board of Health
or its Agent.

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.

84

HELENA (McGINNIS) JACKSON

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)

PHYSICIAN — IMPORTANT

(a) Permanent Residence. No. 105 GROVERS AVE

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 5, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
3/25, 1967, to 4/5/67, 1967I last saw him alive on 4/5/67, 1967, death is said to
have occurred on the date stated above, at 4:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

(b) Left Hemiplegia

(c)

OTHER
SIGNIFICANT
CONDITIONS

Old CVA

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. Potts, M. D.
D. D. Potts, M. D.

(Print or Type Name)

(Address) 12A Pennington St. Date 4/5/67

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

DATE OF BURIAL April 8, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed

APR 7 1967

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

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

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Henry M. Jackson
(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 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 Edward C. McGinness

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

19 MAIDEN NAME OF MOTHER Ellen G. Scannell

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

21 Informant Mrs. Philip Monaghan

(Address) 307 Bowdoin St.

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

Philip G. Velagiano vs.

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

PRINT 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 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).

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

RULES OF PRACTICE

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

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

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

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

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

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

INSTRUCTIONS
FOR
CERTIFICATE1 giving
OF DEATH

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

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

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

conditions contrib-
uting to death but not
causing the terminal
condition given

Chapter 137,
1954, requires
physicians to print or
write the cause or
causes of death on
the certificate.

Medical examiner notified - referred to Board of Health

100M-11-55-9

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 100 FREMONT ST.

2 FULL NAME EILEEN AGNES CORLISS
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 100 FREMONT
(Usual place of abode)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 8, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19I last saw him alive on 19 death is said to
have occurred on the date stated above, at 5:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) death presumably due
to natural causes, probably
acute coronary occlusion

(b) acute coronary occlusion

Winthrop Board of Health

(c) Charles Liberman, M.D.

OTHER
SIGNIFICANT
CONDITIONS CHARLES LIBERMAN

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) Charles Liberman, M.D.

(Address) Winthrop, Mass. Date 4/8/67 1967

6 SAINT PATRICKS AMHERST, N.H.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 11, 1967

7 NAME OF FUNERAL DIRECTOR SMITH AND HEALD
ADDRESS 37 Elm St, Milford, N.H.

Received and filed APR 10 1967 19

(Registrar)

The Commonwealth of Massachusetts

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

STANDARD

CERTIFICATE OF DEATH

Registered No. 85

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

PERSONAL AND STATISTICAL PARTICULARS

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

11 IF STILLBORN, enter that fact here.

12 AGE 53 Years 3 Months Days If under 24 hours
Hours Minutes13 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No.

16 BIRTHPLACE (City) MILFORD
(State or country) NEW HAMPSHIRE

17 NAME OF FATHER Peter F. CLARKIN

18 BIRTHPLACE OF FATHER (City) CO. CANTON,
(State or country) IRELAND

19 MAIDEN NAME OF MOTHER ALICE GARITY

20 BIRTHPLACE OF MOTHER (City) MILFORD
(State or country) NEW HAMPSHIRE21 Informant: MODEY BELL CORLISS
(Address) 100 FREMONT STREETI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip B. Magliano
(Signature of Agent of Board of Health or other)Director of Public Health April 8, 1967
(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 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

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-3-62-932695

PLACE OF DEATH

Worcester

(County)

Gardner

(City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATHGardner
(City or Town making this return)

Registered No. 86

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

2 FULL NAME Freda Ann (Novosel) Koumanelis
(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. 236 Lincoln St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years 3 months 3 days. In place of residence 17 years 3 months 3 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 10 1967
(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.)

1. Multiple Rib Fractures

2. Fracture of Sternum

3. Internal Chest Injuries

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury 1:00 p.m. 4/7 19 67

IF ACCIDENTAL, was injury causally related to the death? yes

Where did Injury occur? Templeton, Mass.
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place? State Highway
(Specify type of place)Manner of Injury Car Collision
(How did injury occur?)

Nature of Injury Chest Injuries

While at work? no Was autopsy performed? yes

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

If so, specify

(Signed) Joseph P. Marnane, M. D.

(Address) Gardner, Mass. Date 4/10 1967

7 Oak Grove Cem. Medford, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 13 19 67

8 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop, Mass.

Received and filed 19

(Registrars of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

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

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

13 AGE 45 Years 10 Months 26 Days If under 24 hours Hours Minutes

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

15 Industry or Business: Own Home

16 Social Security No. 017-16-0964

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

18 NAME OF FATHER John Novosel

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

20 MAIDEN NAME OF MOTHER Emma Last

21 BIRTHPLACE OF MOTHER (City) Germany
(State or country)22 Informant William Koumanelis
(Address)

236 Lincoln St., Winthrop, Mass.

A TRUE COPY

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

DATE FILED April 14 1967

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

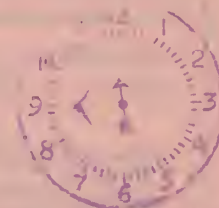
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

APR 25 '67 AM



CLERK
WINSTON, MASS.

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

WINTHROP

(City or Town making this return)

 PLACE OF DEATH
 1 Suffolk
 Winthrop
 (City or Town)

 STANDARD
 CERTIFICATE OF DEATH

Registered No. 87

 No. Bay View Nursing Home
 Charles H Mitton

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

PHYSICIAN — IMPORTANT

 2 FULL NAME Charles H. Mitton
 (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

6 Jefferson St.

Winthrop, Mass.

 (a) Permanent Residence. No. St. Winthrop, Mass.
 (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH April 10 1967
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from May 19 65 to April 10 1967
 I last saw him live on April 8 1967, death is said to have occurred on the date stated above, at 3:46 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

 (a) Myocardial Heart Disease
 (b) Atherosclerosis generalized

 Due To
 (c)

OTHER SIGNIFICANT CONDITIONS

Senile

INTERVAL BETWEEN ONSET AND DEATH

 yp
 yp

 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 H. Gorie, M. D.

 (Print or Type Name) Joseph H. Gorie
 (Address) 194 Washington St. Winthrop, Mass.
 Date 4/10/67

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

DATE OF BURIAL April 14th 67

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed APR 12 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

12 AGE 95 Years 5 Months 12 Days If under 24 hours Hours Minutes

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

14 Industry or Business Self employed

15 Social Security No. 007-30-5227

16 BIRTHPLACE (City) Lee (State or country) Maine

17 NAME OF FATHER Hozin Mitton

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

19 MAIDEN NAME OF MOTHER Emily Lee

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

21 Informant James Mitton

(Address) 156 East 79th St. New York City

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) Philip P. Vitagliano

(Official Designation) Dir. of Pub. Health (Date of Issue of Permit) 4/12/67

 The 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
 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
 above cause (a),
 stating the under-
 lying cause last.

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

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.

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

88

Registered No.

Suffolk

(County)

Winthrop

(City or Town)

58 Thornton Park

No.

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

PHYSICIAN — IMPORTANT

William John Cooper

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)

58 Thornton Park

Winthrop, Mass.

(a) 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 APRIL 11 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased, from
Dec 21, 1964 to APRIL 11, 1967I last saw him alive on APRIL 11, 1967 death is said to
have occurred on the date stated above, at 5:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) NETHROSCLEROSIS WITH
URICEMIAINTERVAL
BETWEEN
ONSET AND
DEATH

1 MC

Due To (b) ANTERIOR SCHEMATIC HEART DISEASE 3 YRS.

Due To (c) WITH CONGESTIVE PHLEGMIA
+ MYOCARDIAL ISCHEMIA

OTHER SIGNIFICANT CONDITIONS CHRONIC BRONCHITIS

5 YRS.

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.

MYRON H. KING M.D.

(Print or Type Name)

(Address) 22 PLEASANT ST. Date APRIL 11, 1967

WINTHROP, MASS.

6 St Josephes St John N.B.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 15 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed APR 12 1967

John A. Clark

(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 S Mae Quinn
HUSBAND of (Give maiden name of wife in full)

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

12 AGE 89 Years 5 Months 18 Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation Clerk (retired)
(Kind of work done during most of working life)

14 Industry or Business Tobacco Store

15 Social Security No. None

16 BIRTHPLACE (City) Coldbrook
(State or country) New Brunswick

17 NAME OF FATHER William T Cooper

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

19 MAIDEN NAME OF MOTHER Mary Palmer

20 BIRTHPLACE OF MOTHER (City) St John
(State or country) New Brunswick

21 Informant Marion Thomas

(Address) 58 Thornton Park Winthrop, Mass.

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

Philip S. Vitagliano (S)

(Signature of Agent of Board of Health or other)

Dir of Public Health 4/12/67

(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
IC. CERTIFICATEIN OR TYPE
SICR CAUSES
OF DEATHdid not enter
ne than one
ate for each
(a (b) and (c)is does not mean
nle of dying,
c heart failure,
ni etc. It means
disse, or compli-
ns which causedond ons, if any,
ic gave rise to
own cause (a),
is the under-
ing cause last.Conditions contrib-
death but not
ed the terminal
se 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

WINTHROP

(City or Town making this return)

FORM R-301



STANDARD

CERTIFICATE OF DEATH

Registered No. 89

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).

Medical examiner notified - Referred to Board of Health

1 PLACE OF DEATH
SUFFOLK
(County)
WINTHROP
(City or Town)
No. CLIFF House Nursing Home2 FULL NAME Sylvester Ranalli
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 141 MERIDIAN St. East Boston, Mass.
(City or town and State)

Length of stay: In place of death 11 years months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 11 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
I last saw him alive on....., 19....., death is said to
have occurred on the date stated above, at 2:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to
(b) natural causes, probably

(c) Recurrent cerebrovascular occlusion

OTHER
SIGNIFICANT
CONDITIONS

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, MASS. Date 4/11/67

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

DATE OF BURIAL April 14 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. McGrath

ADDRESS East Boston

Received and filed APR 12 1967

J. R. O'Connell (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Single11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 69 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Machine Operator
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 021-09-5651

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Sylvester Ranalli

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

19 MAIDEN NAME OF MOTHER ANNA Di Bacco

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant ROSE CAMERON
(Address) 141 Meridian St. E. BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano R.P.

(Signature of Agent of Board of Health or other)

Dir. of Public Health 4/12/67

(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

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. 90

No. Winthrop Community Hospital (If death occurred in a hospital or institution,
St. give its NAME instead of street and number)2 FULL NAME Winifred J. Shea (Hedderman)
(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. 120 Yeaman St. 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 4 14 67
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from 2/17, 1965, to 4-14, 1967.
I last saw him alive on 4/14, 1967, death is said to

have occurred on the date stated above, at 4:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction

Due To
(b)Due To
(c)

OTHER SIGNIFICANT CONDITIONS Hypertension

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) John A. De Luca, M. D.
(Print or Type Name)

(Address) 550 Oak Grove Ave. Date 3/14 1967

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

DATE OF BURIAL April 18, 1967

7 NAME OF FUNERAL DIRECTOR William J. Killion

ADDRESS 1 Sprague Street Revere, Mass.

Received and filed 1967

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 (Give maiden name of wife in full) (or) WIFE of Daniel Shea (Husband's name in full)

12 AGE 78 Years 6 Months 18 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) Ireland (State or country)

17 NAME OF FATHER William Hedderman

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

19 MAIDEN NAME OF MOTHER Hanora Finn

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

21 Informant Winifred (Shea) Jacob

(Address) 60 Ocean View Rd. Swampscott

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)

Suffolk
(County)Winthrop
(City or Town)

PLACE OF DEATH

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
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
disease condition given
(a).Winifred J. Shea
4/17/66

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

Winthrop
(City or Town making this return)

FORM R-301

Suffolk
(County)

Winthrop
(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 91

No. 56 Townsend Street

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

PHYSICIAN — IMPORTANT

2 FULL NAME Beatrice Matilda Lee (Benner)
(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. 56 Townsend Street
(Usual place of abode)

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 April 18 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw him alive on....., 19....., death is said to
have occurred on the date stated above, at 8:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due to natural causes.

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

(Address) Winthrop, Mass. Date 4/19/1967

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

DATE OF BURIAL April 20, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed John A. Clark

(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 Wallace C. Lee
(Husband's name in full)

12 AGE 78 Years 11 Months 20 Days If under 24 hours
Hours Minutes

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

14 Industry or Business Chemical Co.

15 Social Security No. 011-01-2451-A

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

17 NAME OF FATHER Morrill Temple Benner

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

19 MAIDEN NAME OF MOTHER Emma W. Witham

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

21 Informant Mr. Wallace C. Lee
(Address) 56 Townsend St. Winthrop

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

Philip S. Petrosians (Signature of Agent of Board of Health or other)

Div of Public Health 4/20/67
(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.

FORM R-301

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, MASS

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

STANDARD
CERTIFICATE OF DEATH

Registered No. 92

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

BESSIE KANEGIS (WEINER)

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)

25 SEA FOAM AVENUE

WINTHROP, MASS

(a) Permanent Residence. No. St. (City or town and State)

Length of stay: In place of death years months 1/2 hr. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 19, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 19, 1967 to April 19, 1967

I last saw her alive on April 19, 1967, death is said to have occurred on the date stated above, at 5:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 1 Hour

Due To Hypertensive Arteriosclerotic 6 yrs.

(b) Heart Disease

(c) OTHER SIGNIFICANT CONDITIONS Bronchial Asthma, 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 Date 4/19/1967

6 AMERICAN FRIENDSHIP West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 21 1967

7 NAME OF FUNERAL DIRECTOR T.O.R.F. Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed APR 21 1967 19

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEM 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 MORRIS KANEGIS (Husband's name in full)

12 AGE 71 Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) RUSSIA (State or country)

17 NAME OF FATHER SAMUEL WEINER

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

19 MAIDEN NAME OF MOTHER BELLA TOBI

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

21 Informant Mrs IRVING STEINBERG

(Address) 25 Sea Foam Ave Wintthrop

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

Philip A. Vitashansky (Signature of Agent of Board of Health or other)

Dir of Public Health 4/20/67 (Official Designation) (Date of Issue of Permit)

File 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, sthenia, 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 (a).

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 21 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP MASS.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

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
disease, or compli-
cation which caused

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

Conditions contrib-
ing death but not
affecting the terminal
condition given

Suffolk

(County)

Winthrop

(City or Town)

No. Viking Nursing Home

Harriet E (Osgood) Turner

2 FULL NAME

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

2 Undine Ave.

(a) Residence. No.

(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years. 3 months.....days. In place of residence. 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 23, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 1966 to April 23, 1967

I last saw her alive on April 21, 1967, death is said to have occurred on the date stated above, at 1:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer Cervix Uterus 8 mos

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Hypertension 2 yrs

Was autopsy performed?

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
(Print or Type Name)

(Address) WINTHROP, MASS. Date 4/24/1967

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

DATE OF BURIAL April 25, 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed APR 25 1967 19

(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. 93

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

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

12 AGE 76 Years 8 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. 013-07-4121

16 BIRTHPLACE (City) Hope Island
(State or country) Maine

17 NAME OF FATHER Joshia Osgood

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

19 MAIDEN NAME OF MOTHER Isa Pingrey

20 BIRTHPLACE OF MOTHER (City) Denmark
(State or country) Maine21 Informant Willard Turner
(Address) 69 Johnson Ave. Winthrop, MassI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 4/24/67
(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.

FORM R-301

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. 94

No. VIKING NURSING HOME

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

PHYSICIAN — IMPORTANT

2 FULL NAME ROSANNA E QUEENAN (MULLEN)

(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. 95 WOODSIDE AVE

St. WINTHROP MASS
(City or town and State)

Length of stay: In place of death 4 years months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 26 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
1956, 19 to APRIL 26, 1967
I last saw her alive on APRIL 25, 1967, death is said to
have occurred on the date stated above, at 10:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY THROMBOSIS

Due To (b) HYPERTENSION

Due To (c) PARKINSONS 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) Francis P. Schaffa, M. D.
FRANCIS P. SCHAFFA
(Print or Type Name)
(Address) 104 BERNARD ST. BOSTON Date APR 26 19676 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 29 1967

7 NAME OF FUNERAL DIRECTOR MADRILE W KIRBY

ADDRESS WINTHROP MASS

Received and filed MAY 1 1967

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 (Give maiden name of wife in full)
(or) WIFE of JOHN P. QUEENAN
(Husband's name in full)12 AGE 56 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation HOME MAKER.
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. 021-07-8579

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

17 NAME OF FATHER JOHN P. MULLEN

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

19 MAIDEN NAME OF MOTHER SARAH ROGUE

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

21 Informant JOHN QUEENAN

(Address) 390 PARK ST WEST ROX.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip E. Vitagliano
(Signature of Agent of Board of Health or other)Ding Bell Hereth 4/27/67
(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.

FORM R-301

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

95

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

STANDARD
CERTIFICATE OF DEATH

Registered No.

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

PHYSICIAN — IMPORTANT

2 FULL NAME Anne Gordon
(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. 1267 Tremont

Roxbury, Mass.

(City or town and State)

Length of stay: In place of death 17 years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 27, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 1950, to April 27, 1967.
I last saw her alive on April 27, 1967, 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 Occlusion 1 hour

(b) Due To Hypertensive Arteriosclerotic 5 yrs.

(c) Due To Heart Disease

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 4/27/1967

6 Hand In Hand West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 28 1967

7 NAME OF FUNERAL DIRECTOR Solomon Funeral Home Inc

ADDRESS 420 Harvard St Brookline Mass

Received and filed APR 27 1967 19.

A TRUE COPY ATTEST:

(Registrar)

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 AGE 86 Years Months Days 13 Usual Occupation Housekeeper
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

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

17 NAME OF FATHER Simeon Gordon

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

19 MAIDEN NAME OF MOTHER Rachel Hart

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

21 Informant Mrs Hyman Housman Niece

(Address) 19 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:Philip S. Vitagliano (mdc)
(Signature of Agent of Board of Health or other)
Director of Public Health 4/27/67
(Official Designation) (Date of Issue of Permit)filed for 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
(a), (b) and (c)This does not mean
mode of dying,
as heart failure,
dementia, etc. It means
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).

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

Revere
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. 96

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

2 FULL NAME Vincent Beatrice (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. 169 Herman St. Winthrop (City or town and State)

Length of stay: In place of death.....years.....months. 29 days. In place of residence 7 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1967, to April 20, 1967. I last saw him alive on April 20, 1967, death is said to have occurred on the date stated above, at 12:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Prostate 4yrs.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Hiatus Hernia 6yrs.

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 J. Palermo, M. D.

(Address) 20 Crescent Ave. Date 4/21/67 Revere

6 St. Paul's Hingham (City or Town) Place of Burial or Cremation

DATE OF BURIAL April 24, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 141 Winthrop St., Winthrop

Received and filed MAY 17 1967 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 Fiorentina Ciampa (Give maiden name of wife in full)

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

12 AGE 89 Years 11 Months 13 Days If under 24 hours Hours Minutes

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

14 Industry or Business Contractor

15 Social Security No.

16 BIRTHPLACE (City) Italy (State or country)

17 NAME OF FATHER Sabato Beatrice

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

19 MAIDEN NAME OF MOTHER Josephine Barletto

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

21 Informant Sylvia Pace

(Address) 169 Herman St., Winthrop

A TRUE COPY

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

DATE FILED April 24, 1967

MARGIN RESERVED FOR BINDING
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-5-64-938000

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

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

50M-9-59-926111

1

PLACE OF DEATH

Essex

(County)

Lynn

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Lynn

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 97

No. Union Hospital

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

2 FULL NAME Ralph 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, WWI

(a) Residence. No. 58 Beacon

(Usual place of abode)

St. Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 15.....days. In place of residence.....years.....months 10.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20, 1967

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

9/3 1963 4/20 1967

I last saw him alive on 4/20 1967 death is said to

have occurred on the date stated above, at 2 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Broncho pneumonia

Due To Obstructive emphysema

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? xray & clinical state

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

If so, specify

(Signed) L. Michelson

M. D.

(Address) 139 Broad St.

Date 4/20 1967

Lynn, Mass.

6 Winthrop Cem. Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 22, 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS 180 Winthrop St. Winthrop

Received and filed MAY 15 1967

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

married

10a If married, widowed or divorced HUSBAND of Alice E. Budreau

(Give maiden name of wife in full)

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

11 IF STILLBORN, enter that fact here.

12 AGE 72

1

17

If under 24 hours

YEARS.....MONTHS.....DAYS

.....HOURS.....MINUTES

13 Usual Occupation:

Shipping Clerk

(Kind of work done during most of working life)

14 Industry or Business:

G. E. Co.

15 Social Security No.

027-07-8840

16 BIRTHPLACE (City)

(State or country) Newton, Mass.

17 NAME OF FATHER

Edwin R. Burns

18 BIRTHPLACE OF FATHER (City)

c/n/b/1

(State or country)

19 MAIDEN NAME OF MOTHER

Frances Kindred

20 BIRTHPLACE OF MOTHER (City)

(State or country) c/n/b/1

21

Informant Mrs. Alice Burns

(Address) 58 Beacon Street Winthrop

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

4/25 1967

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

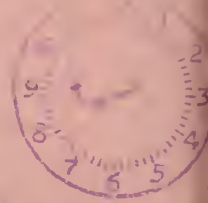
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

MAY 15 '67 A



WINTERMOUNT, MISS

The Commonwealth of Massachusetts

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

Winthrop
(City or Town making this return)

FORM R-301

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 98

No. 36 Bellevue Avenue

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

PHYSICIAN — IMPORTANT

2 FULL NAME Annie Florence Binney (Rowe)
(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. 36 Bellevue Avenue St. Winthrop, Mass.
(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 May 1 1967
(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 11:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To natural causes.

Due To Winthrop Board of Health

OTHER
SIGNIFICANT
CONDITIONS

Charles Liberman M.D.

Was autopsy performed? No

What test confirmed diagnosis? No

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 5/21/1967

6 Mount Auburn Cemetery, Cambridge
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 4, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed MAY 4 - 1967

John A. Clark

(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 Edward Smith Binney
(Husband's name in full)

12 AGE 76 Years 1 Months 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.

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

17 NAME OF FATHER Eli Rowe

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

19 MAIDEN NAME OF MOTHER Mary Ann Cranford

20 BIRTHPLACE OF MOTHER (City) New Harbor
(State or country) Newfoundland

21 Informant Walter E. Rowe

(Address) 752 Main St. Lynnfield Ctr

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

Philip S. Vito (s)
(Signature of Agent of Board of Health or other)
Dir. of Public Health 5/4/67
(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

Filed for burial permit
with Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
NAME OF CAUSE
OF DEATH

do 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
disease condition given
(a).

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. 99

1 PLACE OF DEATH
Winthrop (City or Town)
No. 142 Pleasant St (Viking Nurs. Home) (If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME Anna Walsh (Hingley) (If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Permanent Residence. No. 12 Pico Ave 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, 3 years, 3 months, days. In place of residence, 3 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 2 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
DEC 2 1966, to MAY 2 1967

I last saw him alive on MAY 2 1967, death is said to
have occurred on the date stated above, at 7:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCT

Due To (b) ARTERIO SCLEROTIC HEART DIS 2 YRS

Due To (c) CONGESTIVE FAILURE

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

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

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 223 PLEASANT ST Winthrop Date 5/2 1967

6 Old Calvary Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 3 1967

7 NAME OF FUNERAL DIRECTOR John H. Sawyer

ADDRESS 329 Bunker Hill St. Charlestown

Received and filed MAY 2 1967 19

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 (Give maiden name of wife in full)

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

12 AGE 78 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) May Day Mass. (State or country)

17 NAME OF FATHER Simpson Hingley

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

19 MAIDEN NAME OF MOTHER UNKNOWN

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

21 Informant Mary Bowers
(Address) 12 Pico Ave. Winthrop

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

Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)

Director of Public Health 5/2/67
(Official Designation) (Date of Issue of Permit)

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

RULES OF PRACTICE

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

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

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

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

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

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

The Commonwealth of Massachusetts

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

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 1130

PLACE OF DEATH

Winthrop
(County)
Suffolk
(City or Town)



No. 25 Fremont Street

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

PHYSICIAN — IMPORTANT

2 FULL NAME Catherine Dorothy Ramsey (Finn)
(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. 15 Buchanan Street St. 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 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 3 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec 1955, to May 3, 1967

I last saw her alive on May 3, 1967, death is said to
have occurred on the date stated above, at 6:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction 1 hour

Due To arteriosclerosis

Due To arterial hypertension

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Ecg

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

(Signature) H. B. Greenfield, M. D.
(Print or Type Name)
447 Shirley St.
(Address) Winthrop Date 5-4 1967

6 Holy Sepulchre Cemetery, Coram,
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 2, 1967 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed MAY 8 1967
John A. Allen (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

Female White

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Walter Metcalf Ramsey
(Husband's name in full)

12 AGE 58 Years 9 Months 26 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) Roxbury
(State or country) Massachusetts

17 NAME OF FATHER William Joseph Finn

18 BIRTHPLACE OF FATHER (City) West Roxbury
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Catherine Harris

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

21 Informant John W. Ramsey
(Address) 285 Grant Ave. Islip, N.Y.

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

(Signature of Agent of Board of Health or other)
Philip G. Tatagliano (Mck)
(Official Designation) Director of public health
(Date of Issue of Permit) 5/5/67

A TRUE COPY ATTEST:

FORM R-301

ed for burial permit
Board of Health
r its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
UE OR CAUSES
F DEATH

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

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

ditions, if any,
ght gave rise to
bi: cause (a),
tag the under-
yi cause last.

ditions contrib-
go death but not
ate to the terminal
as: condition given
(a)

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.

FORM R-301

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. 101

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 Daniel J. Tierney (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. 283 Revere St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 14 years months 4 days. In place of residence 4 years months 4 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 4, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from 4/20/1967 to MAY 4, 1967.
I last saw him alive on MAY 4, 1967, death is said to have occurred on the date stated above, at 9:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage
(b) Due To Hypertension and
(c) Due To ArteriosclerosisINTERVAL
BETWEEN
ONSET AND
DEATH15 days
4 yrsOTHER
SIGNIFICANT
CONDITIONS NoneWas autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 5/4/19676 St. Joseph's West Roxbury Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 8, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed MAY 8 1967

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 76 Years Months Days If under 24 hours Hours Minutes

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

14 Industry or Business U.S. Postal Service

15 Social Security No. Cambridge Mass

16 BIRTHPLACE (City) (State or country) Daniel Tierney Ireland

17 NAME OF FATHER Daniel Tierney

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

19 MAIDEN NAME OF MOTHER Mary Brady

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

21 Informant Esther P. Fulmore
(Address) 483 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:

Thrup P. Vitale
(Signature of Agent of Board of Health or other)Dis of Public Health
(Official Designation)5/8/67
(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
he mode of dying,
uch as heart failure,
sthenia, etc. It means
he 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
elated to the terminal
disease condition given
n (a).

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....12-12-17.....

DATE OF DISCHARGE.....9-30-21.....

RANK, RATING AS Ships Cook

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

SERVICE NUMBER.....

.....

RULES OF PRACTICE

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

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

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

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

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

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

PLACE OF DEATH

Middlesex

(County)

Melrose

(City or Town)



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. 102

No. Melrose-Wakefield Hospital

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

2 FULL NAME Esther Marcus (Bergman)

(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. 5 Myrtle Avenue Winthrop, Mass.

(City or town and State)

Length of stay: In place of death... years... months... 30 days. In place of residence... 17 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 6, 1967

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from June 10, 1967, to May 6, 1967

I last saw her alive on May 6, 1967, death is said to have occurred on the date stated above, at 8 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction 5 weeks

Due To (b)

Due To (c) Arteriosclerotic Ht. Disease 10 yrs

OTHER SIGNIFICANT CONDITIONS

Diabetes Mellitus 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) Irving Showstack, M. D.

(Address) Wakefield, Mass. Date May 7, 1967

Winthrop Tifereth Israel Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 7, 1967

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service Inc.

ADDRESS 151 Washington Avenue, Chelsea, Mass.

Received and filed JUN 12 1967

(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 Herbert Marcus
(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 of working life)

14 Industry

or Business: At home

15 Social Security No. None

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

17 NAME OF FATHER

Jacob Bergman

18 BIRTHPLACE OF FATHER (City)

Unable to obtain

(State or country) Russia

19 MAIDEN NAME OF MOTHER

Unable to obtain

20 BIRTHPLACE OF MOTHER (City)

Unable to obtain

(State or country) Russia

21 Informant Herbert Marcus

(Address) 5 Myrtle Avenue, Winthrop, Mass.

TRUE COPY

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

DATE FILED May 9, 1967

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

JUN 12 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS

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)

No

Viking Nursing Home

STANDARD
CERTIFICATE OF DEATH

Registered No. 103

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

PHYSICIAN — IMPORTANT

2 FULL NAME Carrie A (Warner) Buchanan
(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. 70 Thornton Park

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death. 2 years.....months.....days. In place of residence. 26 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 8 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN 1964 to MAY 8 1967
I last saw him alive on MAY 7 1967 death is said to
have occurred on the date stated above, at 11:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic
Due To Heart DISEASE

(b) Due To
(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

24 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. 5/8/67
Date

6 Woodlawn Crematory Everett
Place of Burial or Cremation May 10 67
DATE OF BURIAL

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

Received and filed MAY 10 1967
John Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

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

12 91 10 16
AGE Years Months Days If under 24 hours
Hours Minutes

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

14 Industry or Business Own home

15 Social Security No. 179-01-2411

16 BIRTHPLACE (City) Westhampton Twp.
(State or country) New Jersey

17 NAME OF FATHER Frederick Warner

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

19 MAIDEN NAME OF MOTHER Emma Coer

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

21 Informant Malvern Buchanan
(Address) 300 N. Euclid Ave Pasadena CAL.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Philip S. Vitagliano
(Signature of Agent of Board of Health or other)
Director of Public Health 5/10/67
(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.

FORM R-301

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

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

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
be mode of dying,
uch as heart failure,
sthenia, etc. It means
be disease, or compli-
cations which caused
cath.

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).

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

9 Grovers Ave.

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. 104

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

PHYSICIAN — IMPORTANT

2 FULL NAME William MacFarlane

(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 Grovers Avenue

Winthrop, Mass.

St. (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 9, 1967

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

JAN., 1962, to, MAY 9, 1967

I last saw him live on MAY 9, 1967, death is said to

have occurred on the date stated above, at 1:30 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular

(b) Occlusion

(c) Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Pulmonary Emphysema 5 yrs

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 5/9/1967

6 Cambridge Cem. Cambridge, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL May 12, 1967

7 NAME OF FUNERAL DIRECTOR A. E. Long & Son Inc.

ADDRESS 1979 Mass. Ave. Cambridge,

Received and filed MAY 11 1967

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 Jessie Gillis MacFarlane

(Give maiden name of wife in full)

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

12 AGE 79 Years 4 Months 19 Days If under 24 hours
Hours Minutes13 Usual Occupation Machinist
(Kind of work done during most of working life)

14 Industry or Business: Lever Bros. Retired

15 Social Security No. 012-10-6555

16 BIRTHPLACE (City) Lochee, Scotland
(State or country)

17 NAME OF FATHER William D. MacFarlane

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

19 MAIDEN NAME OF MOTHER Mary Ann MacCormack

20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)21 Informant David MacFarlane
9 Grovers 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:

Philip S. Vetrone (S)

(Signature of Agent of Board of Health or other)

Dir. of Public Health 5/10/67

(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.

FORM R-301

INSTRUCTIONS
FOR
MEDICAL CERTIFICATEIn giving
CAUSE OF DEATHdo not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
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).Note:- Chapter 137,
Acts of 1954 requires
Physicians to print or
type the cause or
causes of death on
death certificates, and
Chapter 48, Acts of
1959, requires Physi-
cians to print or type
name under signature.

OUT-OF-TOWN

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. 105

1 PLACE OF DEATH
Middlesex (County)
Malden (City or Town)
No. Malden Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME Charles J. Jordan (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Residence, No. 224 Court Rd St. Winthrop Mass (Usual place of abode) (If nonresident, give city or town and State)
Length of stay: In place of death.....years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 10 1967 (Month) (Day) (Year)
4 I HEREBY CERTIFY, That I attended deceased from May 1 1967 to May 10 1967
I last saw him alive on May 10 1967, death is said to have occurred on the date stated above, at 9 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

(b) Due To
(c) Due To Gun's arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Carcinoma prostate

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) Clarke Staples M. D.
CLARKE STAPLES M. D.
(Address) MALDEN Date 5/11/67

6 St. Mary's Scituate
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 13 1967

7 NAME OF FUNERAL DIRECTOR Ernest Paggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed MAY 13 1967

Nathan J. Schneidman (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 MARIE A. VINCENT (Give maiden name of wife in full)

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

12 DATE OF BIRTH SEPT 26 1882

13 AGE 84 Years 7 Months 12 Days If under 24 hours Hours Minutes

14 Usual Occupation: Retired Truck Driver (Kind of work done during most of working life)

15 Industry or Business: E. J. Dupont

16 Social Security No. 028-05-1150

17 BIRTHPLACE (City) (State or country) P.E.T. Canada

18 NAME OF FATHER Philip Jordan

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

20 MAIDEN NAME OF MOTHER Sarah Sullant

21 BIRTHPLACE OF MOTHER (City) (State or country) Canada

22 Informant (Address) Agnes Doyle 224 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)

Dir. of Public Health 5/12/67

(Official Designation) 47653 (Date of Issue of Permit)

A TRUE COPY ATTEST:

TRUE COPY ATTEST:

Nathan J. Schneiderman

City Clerk

MAY 16 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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

Essex

(County)

Danvers

(City or Town)

Danvers State Hosp.

No.

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

2 FULL NAME Irving Wadsworth Longfellow

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

Registered No. 106

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

(a) Permanent Residence. No. 15 Thornton St Winthrop, Mass

(City or town and State)

Length of stay: 39 8 28 years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 15 1967

(Month)

(Day)

(Year)

Male

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 briefly.)
April 30 1966 May 15 1967

Bronchopneumonia days

5 Accident, suicide, or homicide (specify)

Pulmonary Emboli (Small) days

If ACCIDENTAL was injury causally related to the death?

When did

Injury

Acute Splenitis days

Cerebral arteriopathy with senile

encephalopathy vs.

Aneurysm of thoracic aorta

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

public place? Yes

(Specify type of place)

Manner of Autopsy

Injury (How did injury occur?)

Nature of

Injury

While working

Willard M Hausman performed?

Willard M Hausman

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

If so, state

Hathorne Mass 5/15/67

(Signed)

Mt. Hope Cemetery Boston, M. D.

(Address) May 17, 1967 Date 19

7 Place of Burial or Cremation Graham Funeral Home

DATE OF BURIAL 19

8 NAME OF FUNERAL DIRECTOR May 18, 1967

ADDRESS

Received and filed JUN 2 1967 19

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Danvers

(City or Town making this return)

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

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

.....

for burial permit
ard of Health
ts Agent.

INSTRUCTIONS
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

ons, if any,
ave 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. Cliff House Nursing Home

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

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 107

2 FULL NAME

Theodore Metcalf

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

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

PHYSICIAN — IMPORTANT

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

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

77 Harbor View Ave. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....14 days. In place of residence 62 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 17 1967
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from
May 17, 1967, to May 17, 1967.
I last saw him alive on May 17, 1967, 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

(b) arteriosclerosis generalized

(c) Parkinson's Disease

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 L. Reynolds M. D.

(Print or Type Name) JOSEPH L. REYNOLDS

(Address) 124 Washington St. 5-17 67

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

DATE OF BURIAL May 20 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed MAY 18 1967

(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 Ellen F Watson
(Give maiden name of wife in full)

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

12 AGE 88 Years 0 Months 29 Days If under 24 hours
Hours Minutes

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

14 Industry or Business U S Government

15 Social Security No. 012-20-6885

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

17 NAME OF FATHER Theodore Metcalf

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

19 MAIDEN NAME OF MOTHER Hannah L Sohier

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

21 Informant John T Metcalf

(Address) 38 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:

Philip S. Vasilian (Signature of Agent of Board of Health or other)

Director of Public Health 5/18/67 (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.

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)1 PLACE OF DEATH
SUFFOLK
(County)
WINTHROP
(City or Town)
No. WINTHROP COMMUNITY HOSPITALSTANDARD
CERTIFICATE OF DEATH

Registered No. 108

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

PHYSICIAN — IMPORTANT

2 FULL NAME MARY (JULIAN) COHEN
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Permanent Residence. No. 262 SHIRLEY ST. WINTHROP MASSACHUSETTS
(City or town and State)

Length of stay: In place of death.....years.....months.....2 days. In place of residence 35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 19, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JULY 1956 to MAY 19 1967
I last saw her alive on MAY 19 1967, death is said to
have occurred on the date stated above, at 8:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION 3 DAYS

(b) ARTERIO SCLEROTIC HEART DIS 3 YRS

(c) HYPERTENSIVE HEART DIS. 10 YRS.

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 15 YRS.

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & ECG5 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 01967
Date 5/19/67Ezra Israel of Malden Danvers
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 21, 1967

7 NAME OF FUNERAL DIRECTOR Paul R. Levine
ADDRESS 470 Harvard St., BrooklineReceived and filed May 23, 1967
John D. Clark

A TRUE COPY ATTEST:

(Registrar)

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 Morris Cohen
(Husband's name in full)12 AGE 74 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation House-wife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. none

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

17 NAME OF FATHER Philip Yotvitsky

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

19 MAIDEN NAME OF MOTHER Mollie (unknown)

20 BIRTHPLACE OF MOTHER (City) cnbl
(State or country) Russia21 Informant Morris Cohen
(Address) 262 Shirley St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vlachopoulos
(Signature of Agent of Board of Health or other)

Dir of Public Health 5/25/67

(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.

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)

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

STANDARD
 CERTIFICATE OF DEATH

Registered No. 109

PHYSICIAN — IMPORTANT

2 FULL NAME Maria Gioiosa
 (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. 16 Frankfort St. East Boston, Mass.
 (City or town and State)

Length of stay: In place of death.....years.....months10days. In place of residence27years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 20, 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 27, 1967, to May 20, 1967, 1967

I last saw deceased on May 20, 1967, death is said to
 have occurred on the date stated above, at 11:30 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Cardiac Dilatation
myocardial infarction

Due To Carcinoma Gall Bladder

(b) Metastasis to Liver

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Nephritis

Was autopsy performed? No

What test confirmed diagnosis? Operation, Laboratory

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

(Signature) Rose E. Jannini, M. D.

Rose E. Jannini, M.D.
 (Print or Type Name)

(Address) 450 Pleasant St. Date May 20, 1967
Winthrop, Mass.

6 St. Michael Cemetery, Boston
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 24, 1967

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., E. Boston, Mass

Received and filed May 24, 1967

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 (Give maiden name of wife in full)

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

12 AGE 79 Years.....Months.....Days
 If under 24 hours
Hours.....Minutes

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

14 Industry or Business At Home

15 Social Security No. None

16 BIRTHPLACE (City).....
 (State or country) Italy

17 NAME OF FATHER Michael Ruggiero

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

19 MAIDEN NAME OF MOTHER Rose Bruno

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

21 Informant Rose Gioiosa (daughter)

(Address) 16 Frankfort 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:

Philip S. Votagiano, Jr.
 (Signature of Agent of Board of Health or other)

Director of Public Health 5/23/67
 (Official Designation) (Date of Issue of Permit)

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,
 senia, etc. It means
 disease, or compli-
 cations which caused
 death.

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

Conditions contrib-
 uting to death but not
 related to the terminal
 disease condition given
 (a).

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

Winthrop
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 110

Suffolk
(County)

Winthrop
(City or Town)

No. 49 Atlantic Street

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

(a) Permanent Residence, No. 49 Atlantic Street
(Usual place of abode)

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

Length of stay: In place of death 42 years.....months.....days. In place of residence 42 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 21 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
5-18, 1967, to May 21, 1967
I last saw her alive on May 19, 1967, death is said to
have occurred on the date stated above, at 7:16 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart disease year
(b) Anterior Sclerosis year
(c) Generalized year

OTHER SIGNIFICANT CONDITIONS Vascular occlusion
Both feet

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 Gregorie, M. D.
(Print of Type Name) Joseph C. GREGORIE
(Address) 194 Washington Ave Date 5-23 1967

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

DATE OF BURIAL May 24, 1967

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

Received and filed May 24, 1967

John A. Gask

(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 (Give maiden name of wife in full)
(or) WIFE of James Harold Strang
(Husband's name in full)

12 AGE 80 Years 8 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. 014-22 -5000

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

17 NAME OF FATHER George E. Marsters

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

19 MAIDEN NAME OF MOTHER Eliza Ann Hurley

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

21 Informant Gordon H. Strang

(Address) 49 Atlantic Street

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

Philip J. Vitagliano
(Signature of Agent of Board of Health or other)

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
AL CERTIFICATE

RT OR TYPE
E OR CAUSES
F DEATH

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

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

ditions, if any,
hs gave rise to
be cause (a),
lating the under-
yi cause last.

ditions contrib-
g death but not
te to the terminal
as condition given
(a)

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

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 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).

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
(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No. 111

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 VIOLA (GIRARDIN) 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. 962 SHIRLEY

St. WINTHROP, MASS.

(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 MAY 23, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
MAY 16, 1967 to MAY 23, 1967
I last saw him live on MAY 23, 1967, death is said to
have occurred on the date stated above, at 1:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive Cardiac Failure

(b) Arteriosclerotic Heart Dis

(c) Arteriosclerosis

OTHER
SIGNIFICANT
CONDITIONS

None

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

(Signature) John F. Collins M.D.

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

(Address) Resere - MASS Date 23 May 1967

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

DATE OF BURIAL MAY 26 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed MAY 25 1967

John A. Clach (Registrar)

A TRUE COPY ATTEST:

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 JOHN A DAVIS
(Husband's name in full)

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

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

14 Industry or Business: HOME

15 Social Security No.

16 BIRTHPLACE (City). WORCESTER
(State or country) MASS

17 NAME OF FATHER CHARLES GIRARDIN.

18 BIRTHPLACE OF FATHER (City) MANATOBA
(State or country) CANADA

19 MAIDEN NAME OF MOTHER STEPHANIE PANDEAU

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

21 Informant JOHN A DAVIS

(Address) 962 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:

Philip P. Volpe
(Signature of Agent of Board of Health or other)
Dir. of Public Health 5/25/67
(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.

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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.

NOTE: CHAPTER 137, ACTS OF 1904, REQUIRES PHYSICIANS TO PRINT
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.

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.

PLACE OF DEATH

Suffolk
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

WINTHROP
(City of Town making this return)

Registered No. 110

No. 56 Moore St.

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

2 FULL NAME Sadie Arvedon
(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) 110

(a) Permanent Residence. No. 56 Moore St. Winthrop Mass
(Usual place of abode) (If nonresident, give city or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 28 1967
(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.)

INCARCERATED EPIGASTRIC
HERNIA. ACUTE INTESTINAL
OBSTRUCTION

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.
(Print name)

(Address) Boston Date 5/28 19 67

7 Ride Of Boston Woburn
Place of Burial or Cremation. May 30 1967

DATE OF BURIAL 19

8 NAME OF FUNERAL DIRECTOR Morris W. Brezniak
ADDRESS 470 Harvard St. Brookline

Received and filed John A. May 29 1967

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

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

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

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

13 AGE 72 Years Months Days If under 24 hours Hours Minutes

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

15 Industry or Business: At Home

16 Social Security No.

17 BIRTHPLACE (City) Russia
(State or country)

18 NAME OF FATHER Unknown

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

20 MAIDEN NAME OF MOTHER Unknown

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

22 Mrs. Agusta Arvedon

Informant (Address) 11 Carol Ave. Brighton, Mass

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

Philip J. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 5/29/67
(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

FORM R-301

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

WINTRHOP

(City or Town making this return)

1 { PLACE OF DEATH
SUFFOLK
(County)
WINTRHOP MASS.
(City or Town)
No. Winthrop Community Hosp.STANDARD
CERTIFICATE OF DEATHRegistered No. 113(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MRS. XXXX FANNIE BAER
(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. 81 UPLAND RD. St. WINTRHOP MASS.
(City or town and State)Length of stay: In place of death hrs years 11 months 11 days. In place of residence 11 years 11 months 11 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 5/29/67
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased, from
5:30 PM 5/24/67 to 6:30 PM 5/29/67I last saw alive on MAY 29 1967, death is said to
have occurred on the date stated above, at 6:45 P M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART DYS
(b) ACUTE CARDIAC ASTHMA
(c) SUPERIMPOSED ON CHRONIC
DIGESTIVE FAILUREINTERVAL
BETWEEN
ONSET AND
DEATH5 YRS
2 HRS
5 YRSOTHER
SIGNIFICANT
CONDITIONS NoneWas autopsy performed? No
What test confirmed diagnosis? CLINICAL5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) Myron N. King M. D.
MYRON N. KING M.D.
(Print or Type Name)(Address) 222 Pleasant St. Date MAY 29 1967
WINTRHOP MASS.6 Woburn Community Center - Woburn
Place of Burial or Cremation (City or Town)DATE OF BURIAL MAY 30 19677 NAME OF FUNERAL DIRECTOR BENJAMIN BIRNBACHADDRESS 1645 Blue Hill Ave MATTAPOIReceived and filed MAY 31 1967 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of MR. ABRAHAM BAER
(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 Home15 Social Security No. —16 BIRTHPLACE (City) Russia
(State or country)17 NAME OF FATHER MORRIS FEINBERG18 BIRTHPLACE OF FATHER (City) Russia
(State or country)19 MAIDEN NAME OF MOTHER Bessie (UNKNOWN)20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant HAROLD FRANK(Address) 25 UPLAND Rd. WINTRHOP.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitasian
(Signature of Agent of Board of Health or other)Director Public Health 5/30/67
(Official Designation) (Date of Issue of Permit)PRINT 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).

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 31 '67



FORM R-301

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)

No. 181 Bartlett Road

STANDARD
CERTIFICATE OF DEATH

Registered No. 114

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

PHYSICIAN — IMPORTANT

2 FULL NAME MARIO CONTI
(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. 181 Bartlett Road St.
(City or town and State)

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 May 30 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19.I last saw him alive on , 19, death is said to
have occurred on the date stated above, at 7:45 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 Lieberman MD

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 Lieberman, M.D.

CHARLES LIEBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 5/30/1967

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

DATE OF BURIAL June 2 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUN 2 1967

John Clark

(Registrar)

A TRUE COPY ATTEST:

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 Nunzia Mollica
(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 Minutes13 Usual Occupation Retired Merchant
(Kind of work done during most of working life)

14 Industry or Business: Fruit & Produce

15 Social Security No. 034-24-4589 A

16 BIRTHPLACE (City). Sicily Italy
(State or country)

17 NAME OF FATHER Angelo Conti

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

19 MAIDEN NAME OF MOTHER Agatha Lazzara

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Mario Conti
(Address) 181 Bartlett RoadI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano (M.D.)
(Signature of Agent of Board of Health or other)Director of Public Health 6/1/67
(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
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).Referred to Board of Health
Medical Examiner waived

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

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)

PLACE OF DEATH

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

Registered No. 115

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,
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).

1 CLIFF HOUSE Nursing Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

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

(a) Permanent Residence. No. 202 Washington Avenue Chelsea, Mass. (City or town and State)

PHYSICIAN — IMPORTANT

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

Length of stay: In place of death 4 years months days. In place of residence 2 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 31 1967
(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 11:00 P.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? No

If so, specify

Charles Liberman M.D.

(Signature) CHARLES LIBERMAN M. D.

(Print or Type Name)

(Address) WINTHROP, MASS. Date 5/31/1967

Greenwood Cemetery Everett, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 2 1967

7 NAME OF FUNERAL DIRECTOR W. R. CARAFA

ADDRESS 389 Washington Ave Chelsea, Mass.

Received and filed JUN 2 1967

John A. O'Leary (Registrar)

A TRUE COPY ATTEST:

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 Selby HAWKINS (Husband's name in full)

12 AGE 86 Years 5 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) (State or country) MFLD CANADA

17 NAME OF FATHER William Lush

18 BIRTHPLACE OF FATHER (City) (State or country) MFLD CANADA

19 MAIDEN NAME OF MOTHER McHugh

20 BIRTHPLACE OF MOTHER (City) (State or country) MFLD CANADA

21 Informant Selby HAWKINS

(Address) 14 Fairfax St. Waltham, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death

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

(Signature of Agent of Board of Health or other)

Official Designation

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

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

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

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

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

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

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

FORM R-301

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 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).

OUT-OF-TOWN

The Commonwealth of Massachusetts

116

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)



STANDARD
CERTIFICATE OF DEATH

Registered No. 62927

DEPT. OF HEALTH & HOSPITALS

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

2 FULL NAME ALEXANDER (MAXIMILIAN) MCGILLIVRAY
(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 Cliff Ave. 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 22, 1967
(Month) (Day) (Year)

WE HEREBY CERTIFY, That WE attended deceased from
March 11, 1967, to March 22, 1967.

WE last saw him alive on March 22, 1967, death is said to
have occurred on the date stated above, at 12:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory and Cardiac Arrest

Due To
(b) Anoxia

Due To
(c) Lobar Pneumonia, Septicemia

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 Averill M.D. Exec. Asst.
(Print or Type Name)

DEPT. OF HEALTH & HOSPITALS Date 3-22-67

6 New Calvary Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 25, 1967

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

Received and filed 3-24-67

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 STELLA LOCKE
(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 Pipe Fitter
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 011-23-2721

16 BIRTHPLACE (City)
(State or country) Prince Edward Island

17 NAME OF FATHER UNKNOWN

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

19 MAIDEN NAME OF MOTHER UNKNOWN

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

21 Informant Anselm C. McLean

Address 412 Granite Ave. Milton

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

(Official Designation)

(Date of Issue of Permit)

(Registrar)

H90
H89

82803 GUY 171007:

William J. Kane.
City Registrar

JUN 22 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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 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).

117

117

62239

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

(City or Town making this return)

Registered No.

STANDARD
CERTIFICATE OF DEATH

No. U.S. PUBLIC HEALTH SERV. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FRANCIS MC DONALD (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, WW#1 & 2 if so specify WAR)

(a) Permanent Residence. No. 106 BARTLETT RD. St. WINTHROP, MASS (City or town and State)

Length of stay: In place of death, years months 1 days. In place of residence 28 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 31 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from March 31, 1967, to March 31, 1967

1 last saw him live on March 31, 1967 death is said to have occurred on the date stated above, at 12 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CONGESTIVE HEART FAILURE 24 hrs

(b) METASTATIC CARCINOMA 24 hrs

(c) LUNG CANCER 2 1/2 yrs

OTHER SIGNIFICANT CONDITIONS BRAIN ABCESS 2 1/2 yrs

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

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

(Signature) Aaron W. Kemper, M. D. (Print or Type Name)

(Address) USPHS Hqs. p. Boston Date April 1, 1967

6 Arlington National Arlington, Va. (City or Town)

DATE OF BURIAL April 4, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed APR 5 1967

(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 Gertrude L. Meleedy (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 Retired U.S.C.G. (Kind of work done during most of working life)

14 Industry or Business U.S.C.G.

15 Social Security No.

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

17 NAME OF FATHER John McDonald

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

19 MAIDEN NAME OF MOTHER Mary Bourke

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

21 Informant Gertrude McDonald (Address) 106 Bartlett Road Winthrop, Mass

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)

Apr 3, 1967 (Date of Issue of Permit)

163
571
X71

A TRUE COPY OF THE

Wm. J. Kane
JUN 26 1867

JUN 26 '67 AM



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. 68803

No. Massachusetts General Hospital BAKER MEMORIAL

Antonetta

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

PHYSICIAN — IMPORTANT

2 FULL NAME Anna REGGIONE
(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. 4 Johnson Ave St. Winthrop Mass
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 4-3-67
(Month) (Day) (Year)4 I HEREBY CERTIFY, That attended deceased from 3-31, 1967, to 4-3-67, 1967I last saw him alive on 4-3-67, 1967, death is said to have occurred on the date stated above, at 3:15 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Intracerebral Hemorrhage

Due To

(b)

Due To

(c)

Essential Hypertension

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? noWhat test confirmed diagnosis? clinical5 Was disease or injury in any way related to occupation of deceased? If so, specify no(Signature) C. L. Clay, M. D.Charles L. Clay, M.D.
(Print or Type Name)(Address) Asst. Dir., Mass. Gen'l. Hosp. Date 4-3-19676 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)DATE OF BURIAL April 6, 19677 NAME OF FUNERAL DIRECTOR Anthony P. RapinoADDRESS 9 Chelsea St. East Boston, Mass.Received and filed APR 7 1967, 1967

(Registrar)

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 _____ (Give maiden name of wife in full)
 (or) WIFE of Domenic Reggione
 (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. _____

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

 17 NAME OF FATHER Joseph Brogna

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

 19 MAIDEN NAME OF MOTHER Emanuella Capobianco

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

 21 Informant Emanuella Gurliaccio (daughter)
(Address) 4 Johnson 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:

Eugene Henry E 07284
 (Signature of Agent of Board of Health or other)

April 5 1967
 (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
 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.

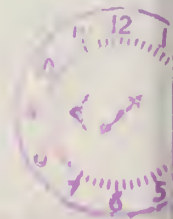
 Conditions contrib-
 uting to death but not
 related to the terminal
 disease condition given
 in (a).

 ineral Directors
 please use only
 BLACK ink.

A TRUE COPY ATTEST:

William J. Kane
Clerk

JUN 26 '67



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 compli-
cations which caused
death.

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

Conditions contrib-
uting to death but not
related to the terminal
disease condition given
in (a).

Suffolk

(County)

Boston

(City or Town)

No.

Veterans Administration Hospital

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

2 FULL NAME

Charles J. BURKE

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

80 Washington

Winthrop, Mass.

(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 April 5 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That VA attended deceased from
March 13 19 67, to April 5 19 67.
death is said to
have occurred on the date stated above, at 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Aspiration secondary to small
bowel obstruction (volvulus at(b) ligament of trites)(acute
gangrene entire jejunum and ileum)Due To
(c)INTERVAL
BETWEEN
ONSET AND
DEATH

hrs.

OTHER SIGNIFICANT CONDITIONS Carcinoma left main stem (mos)
bronchus with local metastasis

Was autopsy performed?

What test confirmed diagnosis? Autopsy

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

(Signature) William Johnson, Jr., M. D.

(Print or Type Name)

(Address) VAH, Boston, Mass Date Apr 6 19 67

6 Winthrop Cem., Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 8 19 67

7 NAME OF FUNERAL DIRECTOR Kirby Funeral Home

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed

APR 10 1967

A TRUE COPY ATTEST:

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No.

(City or Town making this return)

PHYSICIAN — IMPORTANT

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

WWII

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Divorced

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

7

Months

12

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

Bookkeeper (Retired)

(Kind of work done during most of working life)

14 Industry

or Business:

15 Social Security No.

023 05 0559

16 BIRTHPLACE (City)

Medford

(State or country)

Mass.

17 NAME OF

FATHER

Thomas F. Burke

18 BIRTHPLACE OF

FATHER (City)

Springfield,

(State or country)

Mass.

19 MAIDEN NAME

OF MOTHER

Alicia Mann

20 BIRTHPLACE OF

MOTHER (City)

Ireland

(State or country)

21 Informant

V. A. Hospital Records

150 So. Huntington Ave.

(Address)

Boston, Mass.

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

Signature of Agent of Board of Health or other

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kace.
Clerk Recorder

JUN 26 '67 AM



THE TOWN CLERK
WINTHROP, MASS.

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.

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

OUT OF SUFFOLK

PLACE OF DEATH

(County)
BOSTON

(City or Town)

Massachusetts General Hospital

No.

LEWIS

COHEN

2 FULL NAME

(First Name)

(Middle Name)

(Last Name)

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

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

109 Shore Drive,

Winthrop

(If nonresident, give city or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 6, 1967
(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 skull. Bilateral
subdural hematomas.

5 Accident, suicide, or homicide (specify) Accident.

Date and hour of injury April 6, 1967

IF ACCIDENTAL, was injury causally related to the death? Yes.

Where did injury occur? Revere, Mass.
(City or town and State)

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

Manner of injury Fall from ladder.
(Specify type of place)

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 4/7 1967

7 MERTZ CEMETERY WOBURN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 7-1967

8 NAME OF FUNERAL DIRECTOR Solomon Funeral Home
ADDRESS 420 HARVARD ST BROOKLINE

Received and filed

A TRUE COPY ATTEST:

(Registrar)

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

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

(City or Town making this return)

(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

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

13 AGE 78 Years Months Days If under 24 hours
Hours Minutes

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

15 Industry or Business: ELECTRICAL SUPPLY

16 Social Security No.

17 BIRTHPLACE (City) NEW YORK CITY
(State or country) NEW YORK

18 NAME OF FATHER WOLFE COHEN

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

20 MAIDEN NAME OF MOTHER LIBBY UNKNOWN

21 BIRTHPLACE OF MOTHER (City) ENGLAND
(State or country)

22 Informant IRVING COHEN (SON)

20 LEWIS 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:

Regina Leonard F-07869
(Signature of Agent of Board of Health or other)

April 7 1967
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST-

William J. Lane
City Registrar

JUN 26 '67



FORM R-301

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. 00502

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

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

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
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
listed to the terminal
cause condition given
(a).

2 FULL NAME Mrs. Agnes Smith (Reynolds)
(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 WARI) no

(a) Permanent Residence. No.

84 Viking Gardens, Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months 20 days. In place of residence 1 years 7 months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 9, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That deceased died from
3/27/67, 19, to April 9, 1967, 19.

last saw her alive on April 9, 1967, 19, death is said to
have occurred on the date stated above, at 12/35 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Infarction

Due To Cerebral Thrombosis

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Multiple Pulmonary Emboli

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) Charles L. Clay, M.D.

(Print or Type Name)

(Address) 200 N. Dr., Mass. Gen'l. Hosp. Date 4/9/67 19

6 Green Lawn Cem. Nahant Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Wed 12, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St Winthrop

Received and filed APR 13 1967

A TRUE COPY ATTEST:

(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) (or) WIFE of Howard Joseph Smith (Husband's name in full)

12 AGE 81 Years 7 Months 7 Days If under 24 hours Hours Minutes

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

14 Industry or Business retired

15 Social Security No. 015-20-0962

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

17 NAME OF FATHER James F Reynolds

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

19 MAIDEN NAME OF MOTHER not known

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

21 Informant Howard Smith (Address) 84 Viking Gardens 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)

E07996 (Official Designation) 4/10/67 (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane

APR 27 1873



MI-8-66-943275

A TRUE COPY ATTEST:

William H. Kase.
City Recorder

JUN 23 '67 AM



JOHN HARRIS
JOHN HARRIS

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS122
(City or Town making this return)

SUFFOLK - TOWN

BOSTON

(County)

(City or Town)

No.

Massachusetts General Hospital BAKER MEMORIAL

2 FULL NAME Goly Yen

(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, W.W.1.
If so specify WAR)

(a) Permanent Residence. No. 476 Shirley Street, Winthrop, Massachusetts

(City or town and State)

Length of stay: In place of death, years months 2 days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 18, 1967

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
April 17, 1967, to April 18, 1967

we I last saw alive on April 18, 1967, death is said to

have occurred on the date stated above, at 6.20 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

INTERVAL
BETWEEN
ONSET AND
DEATH

2 days

Due To (b) Coronary artery disease

unknown

Due To (c)

years

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus

4 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) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen. Hosp. Date 4/18/67

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

DATE OF BURIAL April 20, 1967

7 NAME OF FUNERAL DIRECTOR Edw. M. Fitzgibbon

ADDRESS 252 Adams St. Dorchester

Received and filed APR 24 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

Yellow

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Married

11 If married, widowed or divorced
HUSBAND of Ging Goon Hom

(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 Prop.
(Kind of work done during most of working life)

14 Industry or Business Laundry

15 Social Security No. 024-26-5327

16 BIRTHPLACE (City) Vina
(State or country) California

17 NAME OF FATHER unknown

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

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) China
(State or country)21 Informant David Yee
(Address) 182 Thorndike St. BrooklineI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or cremation permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

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).x 20.1
81
x 70Funeral Directors
Please use only
BLACK Ink.

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

JUN 23 '67 A



OFFICE OF THE CITY

WINTHROP, MA

FORM R-301

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
mode of dying,
such as heart failure,
hemiplegia, etc. It means
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).

PLACE OF DEATH

Suffolk

(County)

Winthrop, Mass.

(City or Town)

Winthrop Community Hospital

No.

Byron R. Wasson

2 FULL NAME

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

(a) Permanent Residence. No.

22 Buchanan St.

St.

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months5.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 3 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from

May 19, 1967, to June 3, 1967

I last saw him alive on June 3, 1967, death is said to

have occurred on the date stated above, at 2:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion 2hr

(b) Myocardial Heart 4rs

(c) Hypertension essential 4rs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? No

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

(Signature) Dr. Joseph Gregorie, M. D.

(Print or Type Name)

(Address) 194 W. 112th St. Date 6-3-67

(City or Town)

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 7, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUN 7 1967

(Registrar)

A TRUE COPY ATTEST:

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

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

Registered No.

124

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 Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED Widowed
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Florence Hadley
(Give maiden name of wife in full)

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

12 AGE 60 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Proprietor
(Kind of work done during most of working life)

14 Industry or Business Florist

15 Social Security No. 024-03-0486

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

17 NAME OF FATHER Ernest E. Wasson

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

19 MAIDEN NAME OF MOTHER Martha Hazel

20 BIRTHPLACE OF MOTHER (City) C.B.L.
(State or country)

21 Informant Byron R. Wasson Jr.

(Address) Edgehill Rd Winthrop

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

Philip G. Votaghian (3)

(Signature of Agent of Board of Health or other)

Sir of Public Health 6/7/67

(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.

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
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
disease condition given
(a).

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. 125

PLACE OF DEATH

SUFFOLK
(County)
WINTHROP
(City or Town)



No. 39 SEA FOAM AVENUE St. (If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME FANNIE BLOCH
(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. 39 SEA FOAM AVENUE 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 JUNE 6 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
AUG 15, 1962, to JUNE 6, 1967
I last saw her live on JUNE 2, 1967 death is said to
have occurred on the date stated above, at 12:58 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL INFARCTION

INTERVAL
BETWEEN
ONSET AND
DEATH
30

Due To (b) ARTERIO-SCLEROTIC 54 YRS

Due To (c) HYPERTENSIVE HEART DISEASE 2 YRS

WITH CONGESTIVE FAILURE
HEART BLOCK

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 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) Myron N. King, M.D.

(Print or Type Name) MYRON N. KING, M.D.

(Address) 222 Pleasant St. WINTHROP Date 6/6/67

6 TELEETH ISRAEL OF WINTHROP - EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 7, 1967

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLOV

ADDRESS 1668 BEACON ST. BROOKLINE

Received and filed JUN 8 1967

John A. Clark (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 MYER BLOCH
(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 PESACH GROMAN

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

19 MAIDEN NAME OF MOTHER TRIYA BARON

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

21 Informant MORRIS BLOCH

(Address) 1 WHITMAN ROAD SWAMPSCOTT

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

Philip S. Vitashansky (Signature of Agent of Board of Health or other)

Dir. of Public Health 6/6/67 (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.

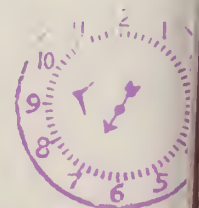
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

JUN 8 '61



OFFICE OF THE TOWN
WINTHROP, MA.

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCambridge
(City or Town making this return)Middlesex
(County)
Cambridge
(City or Town)COPY OF
CERTIFICATE OF DEATH

Registered No. 802

No. Holy Ghost Hospital
St. (If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME Marguerite Wickwire (Dilling)
(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. 54 Shirley St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death 2 years 24 months 4 days. In place of residence 47 years 11 months 25 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 6, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from Mar. 13, 1967 to June 6, 1967
I last saw him alive on June 6, 1967, death is said to have occurred on the date stated above, at 6:17 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

(b) Metastatic Carcinoma of Breast

(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

(Signature) Samuel R. Gargano, M. D.

(Address) Holy Ghost Hosp. 6-6, 1967

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

DATE OF BURIAL June 9, 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed JUL 5 1967

(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 Warren A. Wickwire (Husband's name in full)

12 AGE 57 Years 11 Months 25 Days If under 24 hours Hours Minutes

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

14 Industry or Business Kindergarden

15 Social Security No. 021-12-3267

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

17 NAME OF FATHER James Dilling

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

19 MAIDEN NAME OF MOTHER Margaret McCabe

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

21 Informant William Wickwire (Address) 54 Shirley St. Winthrop

A TRUE COPY

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

DATE FILED June 7, 1967

MARGIN RESERVED FOR BINDING
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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

JUL 5 87 AM



OFFICE OF THE JUDGE ADVOCATE
NAVY DEPARTMENT
WASHINGTON, D.C.

FORM R-301

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.

127

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

Winthrop, Mass.

(a) Permanent Residence. No. 110 Circuit Rd. 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 June 12/67
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
I last saw him alive on June 12, 1967, death is said to have occurred on the date stated above, at 12:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 5/6/67

(b) Asphyxia 6/12/67

(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) M. D.

(Print or Type Name)
(Address) Date June 12/676 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 10 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed JUN 12 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Single
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 84 Years 2 Months 24 Days
If under 24 hours
Hours Minutes13 Usual Occupation At home
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 033-34-4485

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

17 NAME OF FATHER Christian Rausch

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

19 MAIDEN NAME OF MOTHER Amelia Rudolph

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

21 Informant Willard Lutze

(Address) 110 Circuit Rd. Winthrop, Mass.

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

Philip L. Vitagliano (M.D.)
(Signature of Agent of Board of Health or other)Director of Public Health 6/9/67
(Official Designation) (Date of Issue of Permit)filed for 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
(a), (b) and (c)This does not mean
mode of dying,
such as heart failure,
asphyxia, 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
disease condition given
in a).

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

RULES OF PRACTICE

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

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

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

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

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

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

PLACE OF DEATH

1

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

Registered No.

128

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 Ada Gilbert (Miller)
(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

Winthrop, Mass.

(a) Permanent Residence. No. 103 Summit Ave.

St. (City or town and State)

Length of stay: In place of death years months 2 days. In place of residence 34 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 9 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from June 6 1967 to June 9 1967

I last saw her alive on June 9 1967, death is said to have occurred on the date stated above, at 4:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myxedema

INTERVAL
BETWEEN
ONSET AND
DEATH

2 months

(b) Due To

(c) Due To

(d) Due To

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. Date 6/9/1967

6 RAB. ISAAC ELCHONAN - EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 11 1967

7 NAME OF FUNERAL DIRECTOR TORI Funeral Service

ADDRESS 151 WASHINGTON Ave Chelsea

Received and filed JUN 13 1967

John Allen (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Fem 9 COLOR White 10 SINGLE (write the word) MARRIED
MARRIED WIDOWED DIVORCED UNKNOWN11 If married, widowed, or divorced /
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of HYMAN GILBERT
(Husband's name in full)12 AGE 73 years Months Days If under 24 hours
Hours Minutes13 Usual Occupation AT Home
(Kind of work done during most of working life)

14 Industry or Business None

15 Social Security No. None

16 BIRTHPLACE (City) WALSLEY ENGLAND
(State or country)

17 NAME OF FATHER ZALMON MILLER

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

19 MAIDEN NAME OF MOTHER CRL

20 BIRTHPLACE OF MOTHER (City) ENGLAND
(State or country)21 Informant HENRY S GILBERT
(Address) 15 Sheridan Rd ANDOVER

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

(Signature of Agent of Board of Health or other)
(Official Designation) (Date of Issue of Permit)

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

RULES OF PRACTICE

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

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

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

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

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

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

JUN 11 1917
DEPT OF THE ARMY
WINTER

for burial permit
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
ee, or compli-
which caused

ms, if any,
have 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

WINTHROP

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

WINTHROP

(City or Town)

No.

Cliff House Nursing Home

STANDARD CERTIFICATE OF DEATH

Registered No.

129

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

PHYSICIAN — IMPORTANT

2 FULL NAME

FANNIE LEMENT

(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.

1343 Collins Ave

St. MIAMI BEACH FLA.

(Usual place of abode)

(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

June 14, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
April 1966, to June 14, 1967

I last saw her alive on June 14, 1967, death is said to

have occurred on the date stated above, at 2:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of colon

(b) with metastases

(c) to abdomen and bladder

INTERVAL
BETWEEN
ONSET AND
DEATH

1 1/2 yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

No

What test confirmed diagnosis? Surgical, path.

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

(Signature)

Charles Liberman
CHARLES LIBERMAN
(Print or Type Name)

M. D.

(Address) WINTHROP, MASS date 6/14/1967

6 WORKMENS CIRCLE Melrose
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 15 1967

7 NAME OF FUNERAL DIRECTOR BENJAMIN BIRNBACH

ADDRESS 1668 BEACON ST. Bklyn

Received and filed

JUN 15 1967

19

John A. Clark

(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 Louis LEMENT

(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.

033-22-8422 A

16 BIRTHPLACE (City)

Russia

17 NAME OF

FATHER

Louis BOBRICK

18 BIRTHPLACE OF

FATHER (City)

Russia

19 MAIDEN NAME

OF MOTHER

Tillie BARRON

20 BIRTHPLACE OF

MOTHER (City)

Russia

21 Informant

MR ISADORE SCHWARTZ

(Address)

47 Dolphin Ave WINTHROP

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

Philip A. Vitagliano

(Signature of Agent of Board of Health or other)

Dir of Public Health 6/15/67

(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.

The Commonwealth of Massachusetts

FORM R-301

SUFFOLK

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

130

PLACE OF DEATH

(County)
WINTHROP

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No.

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

PHYSICIAN - IMPORTANT

2 FULL NAME SAMUEL BRAFF

(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. 43 HUTCHINSON 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 JUNE 15, 1967

(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 to natural causes.(b) Winthrop Board of Health,(c) Charles Liberman, M.D.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NoWhat test confirmed diagnosis? No5 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 6/15/676 BETH DAVID WOBURN

Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 18 19677 NAME OF FUNERAL DIRECTOR TORF Funeral ServiceADDRESS 151 Washington Ave ChelseaReceived and filed JUN 19 1967 19.....John Clark

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

W

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of ROSE ROSS
(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

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

14 Industry or Business

GROCERY STORE15 Social Security No. 033-26-3180

16 BIRTHPLACE (City)

(State or country) Austria

17 NAME OF FATHER

ABRAHAM BRAFF

18 BIRTHPLACE OF FATHER (City)

(State or country) Austria

19 MAIDEN NAME OF MOTHER

ESTHER ??

20 BIRTHPLACE OF MOTHER (City)

(State or country) Austria

21 Informant

Marion LAUB(Address) 49 Hutchinson St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death

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

Philip S. Vasilakian

(Signature of Agent of Board of Health or other)

Sir of Public Health June 17/67

(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.

JUN 19



OFFICE OF THE
 WINTHROP

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

PLACE OF DEATH

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

Registered No. 131

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 Catherine A. Flanagan
(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. 45 Taft Avenue St. Winthrop, Massachusetts
(City or town and State)

Length of stay: In place of death years months 2 days. In place of residence 12 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 15 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from June 10, 1967 to June 13, 1967
I last saw him alive on June 14, 1967 death is said to have occurred on the date stated above, at 7:25 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease yrs
(b) Due To Myocardial Infarction yrs
(c) Due ToINTERVAL
BETWEEN
ONSET AND
DEATHOTHER
SIGNIFICANT
CONDITIONS

Uremia

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. Murphy, M. D.

(Address) 117 Wash. St. Date June 19, 1967

6 Oak Grove Cemetery Medford
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 17, 1967

7 NAME OF FUNERAL DIRECTOR Joseph P. Murphy

ADDRESS 322 Bunker Hill St. Charlestown

Received and filed JUN 19 1967

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 (Give maiden name of wife in full)

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

12 AGE 86 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) Ireland (State or country)

17 NAME OF FATHER Thomas Brady

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

19 MAIDEN NAME OF MOTHER Margaret Greeley

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

21 Informant Helen Mc Comiskey

(Address) 10 Wall St. Charlestown

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

Signature of Agent of Board of Health or other

(Official Designation) (Date of Issue of Permit)

filed for burial permit
h Board of Health
or its Agent.INSTRUCTIONS
FOR
CERTIFICATEINT OR TYPE
USE OR CAUSES
OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)is does not mean
mode of dying,
as heart failure,
mia, etc. It means
disease, or compli-
cations which causedConditions, if any,
which gave rise to
above cause (a),
affecting the under-
lying cause last.Conditions contrib-
uted to death but not
led 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.

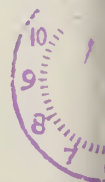
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

JUN 19



OFFICE OF
WINTH

FORM R-301

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.

476 Winthrop Street

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

2 FULL NAME

Ursula (Pastore) DeChristoforo

(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.

476 Winthrop Street

St.

Winthrop

(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 June 16, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
to 19 to 19I last saw him 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

(b) Due To natural causes.

(c) Due To Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman MD

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) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 6/19/1967

6 St. Michael Cemetery Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 20, 1967

7 NAME OF FUNERAL DIRECTOR Anthony P. Rapino
9 Chelsea St., East Boston, Mass.
ADDRESS

Received and filed JUN 20 1967 19

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 Americo DeChristoforo
(Husband's name in full)12 AGE 70 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business at home

15 Social Security No. None

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Frank Pastore

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

19 MAIDEN NAME OF MOTHER Julia Ressa

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Claire Christopher (daughter)
(Address) 476 Winthrop St., Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Blagham
(Signature of Agent of Board of Health or other)
Dir. of Public Health June 19, 1967
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

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

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

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

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

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

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

The Commonwealth of Massachusetts

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. 133

1 PLACE OF DEATH
Suffolk
(County)
Winthrop
(City or Town)



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

2 FULL NAME Andrew Pugliese
(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. 15 Rockwell St. Dorchester
(City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 17 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 1966 to June 17 1967
I last saw him alive on 6-14-1967 death is said to have occurred on the date stated above, at 6:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial heart disease

(b) Arteriosclerosis

(c) Generally

INTERVAL BETWEEN ONSET AND DEATH
you
you

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 E. Gregorie, M. D.

(Print or Type Name) Joseph E. Gregorie

(Address) 194 Winthrop St. Winthrop Date 6-17 1967

6 St. Michael's Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 19 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS East Boston

Received and filed JUN 19 1967

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 JULIA CAPRIO
(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 CARPENTER
(Kind of work done during most of working life)

14 Industry or Business: RETIRED

15 Social Security No. CAA-033-16-6581T

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER John Pugliese

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

19 MAIDEN NAME OF MOTHER Olympia

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

21 Informant Julia Pugliese

(Address) 15 Rockwell St. Dorchester

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

Philip S. Vitagliano
(Signature of Agent of Board of Health or other)

Sir L. Public Health June 19 1967
(Official Designation) (Date of Issue of Permit)

Filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE NAME 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 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 referred to the terminal illness given in (a).

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.

JUN

PLACE OF DEATH

Middlesex

(County)

Tewksbury, Mass.

(City or Town)

No. TEWKSBURY HOSPITAL

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

TEWKSBURY HOSPITAL

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 111

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 FULL NAME Mary Brooks
(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. 29
27 Washington
(Usual place of abode)St. Winthrop, Mass.
(If nonresident, give city or town and State)Length of stay: In place of death 1 years 1 months 7 days. In place of residence 1 years 1 months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 18, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
May 11, 1966 to June 18, 1967
I last saw him alive on June 18, 1967, death is said to
have occurred on the date stated above, at 10:30 a.m.INTERVAL
BETWEEN
ONSET AND
DEATH
3 Yrs

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) LymphosarcomaDue To Unknown
(b)Due To -----
(c)OTHER SIGNIFICANT CONDITIONS Post Streptococcal meningitis
Urinary Tract Infection Mos.Was autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____(Signed) Melecio H. Flores, M. D.(Address) TEWKSBURY HOSPITAL Date 6-18-19676 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)DATE OF BURIAL 6-21-19677 NAME OF FUNERAL DIRECTOR Frederick Magrath
ADDRESS 325 Chelsea St., E. BostonReceived and filed John A. Clark 19 Supr.

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

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

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 5 Months 12 Days If under 24 hours
----- Hours ----- Minutes13 Usual Occupation: Housework
(Kind of work done during most of working life)14 Industry or Business: At Home15 Social Security No. 021-03-698616 BIRTHPLACE (City) Boston
(State or country) Mass.17 NAME OF FATHER Emmanuel J. Brooks18 BIRTHPLACE OF FATHER (City) cannot be learned
(State or country) Portugal19 MAIDEN NAME OF MOTHER Rosalie Matos20 BIRTHPLACE OF MOTHER (City) cannot be learned
(State or country) Portugal21 Informant (Address) Hospital Records & Undertaker
& Brother

A TRUE COPY

ATTEST: James J. [Signature]
(Registrar of City or Town where death occurred)DATE FILED 6-18-1967

WRITE PLAINLY, WITH UNFADING BLACK INK ON ONE SIDE OF A WHITE CARD, 5 1/2" x 8 1/2" (SEE INSTRUCTIONS ON REVERSE)

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

OTHER TYPE
CAUSES
DEATH

Enter
than one
for each
(b) and (c)

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

is, if any,
be rise to
cause (a),
he under-
use lost.

means contrib-
death but not
the terminal
condition given

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. Bay View Nursing Home

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

(a) Permanent Residence. No. 80 Wellington Road, St. Medford, Mass.
(Usual place of abode) (City or town and State)

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

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 21 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Oct 14, 1965, to June 21, 1967.
I last saw her alive on June 21, 1967, death is said to
have occurred on the date stated above, at 4:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral haemorrhage

Due To (b) Cerebral Hypertension

Due To (c) 0

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) Charles F. Ferrera, M. D.

(Address) 154 Bennington St., East Boston Date 6/21/67

New Calvary Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 24th 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed JUN 22 1967

John A. Clark (Registrar)

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. 135

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

PHYSICIAN — IMPORTANT

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

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
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 78 Years Months Days If under 24 hours
Hours Minutes

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

14 Industry or Business Boston Schools

15 Social Security No. 013-36-5938

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

17 NAME OF FATHER John F. Morrison

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

19 MAIDEN NAME OF MOTHER Jane T. Matthews

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

21 Informant Mrs. Francis D. Morrison

(Address) 80 Wellington Rd., Medford

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

Philip D. Vitagliano Jr.
(Signature of Agent of Health or other)
Div. of Public Health 6/22/67
(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.

JUN 22 '67



FILE TO
CYTROP. N

FORM R-301

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
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
disease condition given
(a).

The Commonwealth of Massachusetts		KEVIN H. WHITE SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS	WINTHROP (City or Town making this return)
1	SUFFOLK (County)	STANDARD CERTIFICATE OF DEATH	Registered No. 136
	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 RUTH A. (SMITH) BELL (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. 54 HIGHLAND AVE., WINTHROP St. (City or town and State)		
Length of stay: In place of death.....years.....months.....days. 28 days. In place of residence 60 years.....months.....days.			
MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3	DATE OF DEATH JUNE 22, 1967 (Month) (Day) (Year)	8 SEX FEMALE	9 COLOR WHITE
4	I HEREBY CERTIFY That I attended deceased from May 19, 1967, to June 22, 1967. I last saw her alive on June 22, 1967, death is said to have occurred on the date stated above, at 2:20 P.M.	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED WIDOWED UNKNOWN	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Heart Disease		11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Martin J. Bell (Husband's name in full)	
Due To (b) Arterio Sclerosis of coronary arteries		12 AGE 87 Years Months Days If under 24 hours Hours Minutes	
Due To (c) Senility		13 Usual Occupation Housewife (Kind of work done during most of working life)	
OTHER SIGNIFICANT CONDITIONS Cerebro-vascular accident		14 Industry or Business Own Home	
Was autopsy performed?		15 Social Security No. ---	
What test confirmed diagnosis?		16 BIRTHPLACE (City) Quincy, Mass (State or country)	
5 Was disease or injury in any way related to occupation of deceased? If so, specify		17 NAME OF FATHER Robert Smith	
(Signature) Joseph L. Gregorie, M. D. (Print or Type Name) (Address) 194 Washington St. Boston 6-22-67		18 BIRTHPLACE OF FATHER (City) Quincy, Mass (State or country)	
6 Winthrop Winthrop Place of Burial or Cremation (City or Town)		19 MAIDEN NAME OF MOTHER Agnes Welch	
DATE OF BURIAL June 24, 1967		20 BIRTHPLACE OF MOTHER (City) C. B. L. (State or country)	
7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley		21 Informant Ruth Kenney (Address) 54 Highland Ave., Winthrop	
ADDRESS Winthrop, Mass.			
Received and filed John A. Clark (Registrar)		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Philip L. Vetrochianakis (Signature of Agent of Board of Health or other) Dir. of Public Health 6/23/67 (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

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

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

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance 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-305

PLACE OF DEATH

Norfolk
(County)Canton
(City or Town)

No.



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

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Canton

(City or town making return)

Registered No.

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

2 FULL NAME Felix F. Albano (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. 151 Bartlett Road St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1 days. In place of residence.....30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 24, 1967
(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 Coronary Thrombosis

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?

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

(Signed) Appleton C. Woodward, M. D.
(Address) Stoughton Mass. Date 6/24, 1967

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

DATE OF BURIAL June 28, 1967

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS Winthrop Mass.

Received and filed JUN 29 1967

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

12 IF STILLBORN, enter that fact here.

13 AGE 58 Years.....Months.....Days If under 24 hoursHours.....Minutes

14 Usual Occupation: Rest Home Operator
(Kind of work done during most of working life)

15 Industry or Business: Rest Home

16 Social Security No.

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

18 NAME OF FATHER Vincent Albano

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

20 MAIDEN NAME OF MOTHER Antonette Diesco

21 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

22 Informant Mary E. Albano
(Address) 151 Bartlett Road, Winthrop

A TRUE COPY ATTEST: Maurice E. Ronayne Jr.
(Registrar of City or Town where death occurred)

DATE FILED June 27, 1967

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, (L.))

25M-4-59-925100

137

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

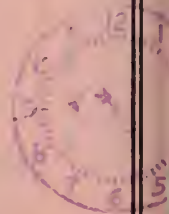
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

JUN 29 67



FORM R-301

The Commonwealth of Massachusetts

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

WINTHROP

(City or Town making this return)

138

PLACE OF DEATH

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

Registered No.

to be filed for burial permit
with Board of Health
or its Agent.INSTRUCTIONS
FOR
MEDICAL CERTIFICATE1. WINTHROP COMMUNITY HOSP (If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME DANIEL P. DOHERTY
(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. 105 GROVERS AVE St. WINTHROP MASS
(City or town and State)PRINT OR TYPE
CAUSE OR CAUSES
OF DEATHLength of stay: In place of death.....years.....months 17 days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 24 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN 37, 1967, to JUNE 24, 1967I last saw him alive on JUNE 24, 1967, death is said to
have occurred on the date stated above, at 6:15 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion(b) Hypertensive - Arterio-(c) Sclerotic Heart DiseaseOTHER
SIGNIFICANT
CONDITIONS Parkinson'sWas 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(Address) WINTHROP, MASS Date 6/24 19676 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)DATE OF BURIAL JUNE 27 19677 NAME OF FUNERAL DIRECTOR MAURICE W KIRBYADDRESS WINTHROP MASSReceived and filed JUN 26 1967 19.....

A TRUE COPY ATTEST:

(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 JENNEY V REED
(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 Minutes13 Usual Occupation NEWS PAPER
(Kind of work done during most of working life)14 Industry or Business: PLANT MAINTENANCE15 Social Security No. 021-10-743416 BIRTHPLACE (City) BOSTON
(State or country) MASS17 NAME OF FATHER GEORGE DOHERTY18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)19 MAIDEN NAME OF MOTHER (UNKNOWN) DEVLIN20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)21 Informant JENNEY V DOHERTY
(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:Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

do not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
mode of dying,
such as heart failure,
hemiparesis, 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).

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

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

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

(Additions contrib-
uting to death but not
leading 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)

STANDARD
CERTIFICATE OF DEATH

Registered No. 139

1 PLACE OF DEATH
SUFFOLK
(County)
WINTHROP
(City or Town)

No. 96 LORING RD

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

PHYSICIAN — IMPORTANT

2 FULL NAME ALICE F DWYER (DAILY)
(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. 96 LORING RD
(Usual place of abode)

St. WINTHROP MASS.
(City or town and State)

Length of stay: In place of death 53 years.....months.....days. In place of residence 53 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 24 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Aug. 17, 1950, to June 24, 1967

I last saw her alive on June 23, 1967 death is said to
have occurred on the date stated above, at 7:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction 20 min

Due To Arteriosclerotic heart 10 yrs
(b) disease

Due To Generalized arterio- 12 yrs
(c) sclerosis

OTHER SIGNIFICANT CONDITIONS Severe hypertrophic 15 yrs
arthritis

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, Jr., M.D.

(Address) 73 Bartlett Rd. Date 6-24 1967
Winthrop, Mass.

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

DATE OF BURIAL JUNE 27 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP MASS.

Received and filed JUN 26 1967

(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 HAPPY J. DWYER
(Husband's name in full)

12 AGE 80 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. HOME

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

17 NAME OF FATHER CHARLES DAILY

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

19 MAIDEN NAME OF MOTHER CATHERINE HAYDE

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

21 Informant ROBERT A. DWYER

(Address) 96 LORING RD WINTHROP

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

Philip J. Vitagliano (R)
(Signature of Agent of Board of Health or other)

Dir. of Public Health 6/26/67
(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.

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.

04778

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 Lottie Parsons
 (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.

30 Bellevue Ave. 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 May 14 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
May 14, 1967 to May 14, 1967
 and last saw him alive on May 14, 1967 death is said to
 have occurred on the date stated above, at 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction 7-8 hrs

(b) Hypertensive & Arterio-
 Sclerotic Heart Disease years

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 cc. clay

(Signature) Charles L. Cloy, M. D.

(Print or Type Name)

(Address) Charles L. Cloy, M.D. Date 5-14 67
Asst Dir. Mass. Genl Hosp.

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

DATE OF BURIAL May 17, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed

MAY 18 1967

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 Widowed

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of George E. Parsons
 (Give maiden name of wife in full)
 (Husband's name in full)

12 AGE 88 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. 022-01-2379A

16 BIRTHPLACE (City) East Boston Mass
 (State or country)

17 NAME OF FATHER John Kelliher

18 BIRTHPLACE OF FATHER (City) New York
 (State or country)

19 MAIDEN NAME OF MOTHER Catherine Tobin

20 BIRTHPLACE OF MOTHER (City) New York
 (State or country)

21 Informant George E. Parsons

(Address) 30 Bellevue Ave., Winthrop, Ma

I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued:

Kenneth W. Hurd
 (Signature of Agent of Board of Health or other)
509324 May 16, 1967
 (Official Designation) (Date of Issue of Permit)

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 mode of dying,
 such as heart failure,
 sthenia, 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).

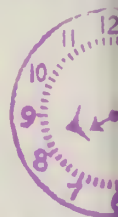
Decided By Medical Examiner

420
 81
 970
 Funeral Director:
 Please use only
 BLACK Ink.
 11 1967
 00M-8-66-94 3275

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

JUL 11



OFFICE OF THE

WINTHROP

JUL 11

To 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.

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. 35, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114,
§§ 41-48.

100M-9-63-936348
If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

SUFFOLK

(County)

BOSTON

(City or Town)



SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

141

(City or Town making this return)

Registered No. 15308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Massachusetts General Hospital

No. _____ St. _____ (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME MARY HARKINS (O'NEEY) (If deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 11 Sumnit Avenue, St. Winthrop, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death _____ years _____ months 4 days. In place of residence 25 years _____ months 2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 31, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Cerebral hemorrhage.

5 Accident, suicide, or homicide (specify) _____
Date and hour of injury _____ 19 _____
IF ACCIDENTAL, was injury causally related to the death? _____
Where did injury occur? _____
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? _____
(Specify type of place)
Manner of Injury _____
(How did injury occur?)
Nature of Injury _____
While at work? _____ Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Michael A. Luongo, M.D.
Print or Type Name
(Address) Boston Date 5/31 1967

7 Holy Cross Malden Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 2 1967

8 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 141 Winthrop St Winthrop
JUN 5 1967
William J. Kane
A TRUE COPY ATTEST (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Patricia W. Harkins (Husband's name in full)

13 AGE 73 Years 5 Months 24 Days If under 24 hours Hours Minutes

14 Usual Occupation: HOUSE WIFE (Kind of work done during most of working life)

15 Industry or Business: AT HOME

16 Social Security No. 022-20-4398

17 BIRTHPLACE (City) (State or country) NEWFOUNDLAND

18 NAME OF FATHER Joseph O'NEEY

19 BIRTHPLACE OF FATHER (City) (State or country) Ireland

20 MAIDEN NAME OF MOTHER UNKNOWN

21 BIRTHPLACE OF MOTHER (City) (State or country) "

22 Informant (Address) Mar y Palandro 21 Howard St Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.
Eugene B. O'Neil E 09926
(Signature of Agent of Board of Health or other) June 1 1967
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

1888

William J. Kane.

City Registrar

FORM R-305

MARGIN RESERVED FOR BINDING
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.)

50W-5-611-938000

PLACE OF DEATH

VETERANS COPY

Middlesex

(County)

Somerville

(City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Somerville

(City or Town making this return)

Registered No. 326

No. Central Hospital Central

(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

2 FULL NAME Chester W. Orris

(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)

(a) Permanent Residence. No. 19 Dartmouth

St. Somerville, Mass.

(City or town and State)

Length of stay: In place of death. years months days. In place of residence. years months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 9, 1967

(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.)Suicide Poisoning (Radiator Flush
Oil)

5 Accident, suicide, or homicide (specify) Suicide

Date and hour of injury June 9, 1967 19 7:30PM

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

(Specify type of place)

Manner of

Injury

(How did injury occur?)

Nature of

Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Sidney S. Listernick Ass. M. D.

Med. Exam.

(Address) 37 Ferry St.,
Everett, Mass. Date June 9, 19 677 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL June 12, 19 67

8 NAME OF FUNERAL DIRECTOR Lawrence A. Willwerth

ADDRESS 179 Highland Ave., Somerville

Received and filed JUL 12 1967 19

(Registrar of City or Town where deceased resided) IS buried

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Married

12 If married, widowed, or divorced
HUSBAND of Marjorie A. McCarthy
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 40 Years 10 Months 23 Days

If under 24 hours

Hours Minutes

14 Usual Occupation: Gas Station Attendant
(Kind of work done during most of working life)

15 Industry or Business: Fuel Business

16 Social Security No.

17 BIRTHPLACE (City) Alsey, Illinois
(State or country)

18 NAME OF FATHER

Lee Orris

19 BIRTHPLACE OF FATHER (City)

Jacksonville, Ill.

(State or country)

20 MAIDEN NAME OF MOTHER

Emma Miller

21 BIRTHPLACE OF MOTHER (City)

Jacksonville, Ill.

(State or country)

22 Informant Mrs. Marjorie A. Orris
(Address)35 Moore St.,
Winthrop, Mass.

TRUE COPY

ATTEST: William J. Danaway
(Registrar of City or Town where death occurred)

DATE FILED June 12, 11:19 AM 19 67

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 2-4-49

DATE OF DISCHARGE 9-29-52

RANK, RATING PFC

ORGANIZATION AND OUTFIT U.S. Army

SERVICE NUMBER RA36928665

.....

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Plymouth

(City or town making return)

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH

Plymouth
(County)

Plymouth
(City or Town)

No. off Route 3, near WPLM Station

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

2 FULL NAME Richard J. Porter

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

1079 Shirley St

Winthrop, Mass

(a) Residence. No.
(Usual place of abode)

St. 24
(If nonresident, give city or town and State)

Length of stay: In place of death none years.....months.....days. In place of residence 24 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

June 18, 1967

(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.)

Compound fracture skull

Crushed chest and trachea

Multiple fractures

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 6PM June 18, 1967

If accidental, was injury causally related to the death? yes

Where did Plymouth, Mass

Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place? Airplane Route 3

Manner of (Specify type of place)
Injury Airplane struck guy wire

Nature of (How did injury occur?)
Injury Guy wire caught airplane

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) William C. Gould M. D.

(Address) Kingston, Mass Date June 18, 1967

7 Place of Burial or Cremation. Winthrop Winthrop
June 21, 1967 (City or town)

DATE OF BURIAL June 21, 1967

8 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St, Winthrop

Received and filed JUL 13 1967

(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 24 Years.....Months.....Days

If under 24 hours

.....Hours.....Minutes

15 Usual Occupation: Maintenance man

(Kind of work done during most of working life)

16 Industry or Business: Eastern Air Line, Boston

17 Social Security No.

18 BIRTHPLACE (City) Winthrop
(State or country) Mass

19 NAME OF FATHER Ronald W Porter

20 BIRTHPLACE OF FATHER (City) Somerville
(State or country) Mass

21 MAIDEN NAME OF MOTHER Evelyn M. Farrell

22 BIRTHPLACE OF MOTHER (City) Jamaica Plain
(State or country) Mass

23 Informant Ronald W Porter
(Address) 1079 Shirley St, Winthrop

A TRUE COPY.

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED June 19, 1967

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

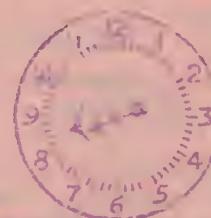
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

JR 13 67 AM



OFFICE OF THE JUDGE ADVOCATE
GENERAL
WINTHROP, ARIZ.

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.

1 PLACE OF DEATH
 WINTHROP COMMUNITY HOSPITAL
 No. LINCOLN ST. WINTHROP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME RUBY G. TUCKER (Gillmore)
 (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. 393 PLEASANT ST. WINTHROP
 (City or town and State)

Length of stay: In place of death.....years. 2 months. 1 days. In place of residence 65 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 4TH 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 3, 1967, to July 4, 1967.
 I last saw him alive on July 4, 1967 death is said to have occurred on the date stated above, at 10:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized Carcinomatosis
 (b) Due To Carcinoma of Pancreas
 (c) ————
 INTERVAL BETWEEN ONSET AND DEATH
 3 Mos.
 5 Mos.

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

(Signature) M. Traustein, Jr. M. D.
 (Print or Type Name)

(Address) 23 Ruffin Rd. Wintthrop, Mass. Date July 4, 1967

6 Winthrop, Cemetery Winthrop, Mass.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 7, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUL 7 1967

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 Sidvin Frank Tucker (Husband's name in full)

12 AGE 77 Years 2 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. 025-26-3891-B

16 BIRTHPLACE (City) Winthrop (State or country) Massachusetts

17 NAME OF FATHER Harry Creighton Gillmore

18 BIRTHPLACE OF FATHER (City) Nova Scotia (State or country)

19 MAIDEN NAME OF MOTHER Ida Floyd

20 BIRTHPLACE OF MOTHER (City) Winthrop (State or country) Massachusetts

21 Informant Sidvin F. Tucker

(Address) 393 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:

Philip G. Vetrochano (Signature of Agent of Board of Health or other)
 Dir. of Public Health 7/7/67 (Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

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. 145

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 59 Beal St.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Herbert Thomas Crosby
(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 Beal ST.
(Usual place of abode)

St. Winthrop
(City or town and State)

Length of stay: In place of death 20 years - months - days. In place of residence 20 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 6, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19....., to 19.....

I last saw him alive on 19....., death is said to
have occurred on the date stated above, at 7:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
(b) 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 7/7/1967

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 10, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St.
Received and filed JUL 11 1967
J. Paul Clack
(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 Eunice (MONEY) Crosby
(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 Navy Yard
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 025-34-9012

16 BIRTHPLACE (City) BOSTON, MASS.
(State or country)

17 NAME OF FATHER Thomas Crosby

18 BIRTHPLACE OF FATHER (City) not known
(State or country)

19 MAIDEN NAME OF MOTHER Mary Kelley

20 BIRTHPLACE OF MOTHER (City) not known
(State or country)

21 Informant Mrs. Eunice Crosby
(Address) 59 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:

Philip G. Vetrovian (2)
(Signature of Agent of Board of Health or other)

Dr. J. Paul Clack
(Official Designation)

7/7/67
(Date of Issue of Permit)

A TRUE COPY ATTEST:

Reported to M.C. office - 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.

FORM R-301

for burial permit
ward of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
FOR CAUSES
OF DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
sue, or compli-
which caused

ons, if any,
have rise to
the cause (a),
in 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

WINTHROP

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 146

No. Cliff House Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

Albert F. Pratt

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)

72 Temple Avenue

(a) Residence, No. (Usual place of abode) 6 St. 20 (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 9, 1967 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY, 1962, to July 9, 1967. I last saw him live on July 9, 1967, death is said to have occurred on the date stated above, at 7:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia, Bilateral 1 wk.

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Cerebral ARTERIOsclerosis 5yrs Hypertension 5yrs.

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) Chas Liberman M.D.

(Address) 238 Shore Dr. Date 17/11 19 67

6 Winthrop Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 12, 19 67

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano 174 Winthrop St., Winthrop

ADDRESS

Received and filed JUL 12 1967 John A. Gark

(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 Katherine Langleax (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 63 Years 8 Months 24 Days If under 24 hours Hours Minutes

13 Usual Occupation boiler inspector (Kind of work done during most working life)

14 Industry or Business Insurance 020-05-4860

15 Social Security No. Salem Mass.

16 BIRTHPLACE (City) (State or country) James F. Pratt

17 NAME OF FATHER Salem Mass.

18 BIRTHPLACE OF FATHER (City) (State or country) Mary Crowley Salem Mass.

19 MAIDEN NAME OF MOTHER Salem Mass.

20 BIRTHPLACE OF MOTHER (City) (State or country) James F. Pratt

21 Informant (Address) 16 Oliver St., Brockton

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Petrosian (Signature of Agent of Board of Health or other)

Sir of Public Health 7/11/67 (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.

FORM R-301

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
of (a), (b) and (c)

This does not mean
a mode of dying,
such as heart failure,
shock, etc. It means
the disease, or compli-
cations which caused
death.

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

Conditions contrib-
uting to death but not
related to the terminal
disease condition given
(a).

The Commonwealth of Massachusetts		KEVIN H. WHITE SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS	WINTHROP, MASS. (City or Town making this return)
1	SUFFOLK (County)	STANDARD CERTIFICATE OF DEATH	Registered No. 147
	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 JOHN J. McLAUGHLIN (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. 26 LOCUST ST.,		St. WINTHROP, MASS. (City or town and State)	
Length of stay: In place of death.....years.....months.....6.....days. In place of residence 50.....years.....months.....days.			
MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH July 14 1967 (Month) (Day) (Year)	4 I HEREBY CERTIFY That I attended deceased from July 8, 1967 to July 14, 1967 I last saw him alive on July 14, 1967, death is said to have occurred on the date stated above, at 10:45 P.M.	5 SEX Male	9 COLOR White
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 6 mos		10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN	
Interval Between Onset and Death		11 If married, widowed, or divorced HUSBAND of Margaret Mackill (Give maiden name of wife in full)	
(b) Due To		(or) WIFE of..... (Husband's name in full)	
(c) Due To		12 AGE 75 Years.....Months.....Days If under 24 hours Hours.....Minutes	
OTHER SIGNIFICANT CONDITIONS: Pulmonary Emphysema 5 yrs Duodenal Ulcer 1 wk		13 Usual Occupation Retired Custodian (Kind of work done during most of working life)	
Was autopsy performed? NO		14 Industry or Business: School	
What test confirmed diagnosis? Clinical		15 Social Security No. So. Orange	
5 Was disease or injury in any way related to occupation of deceased NO If so, specify		16 BIRTHPLACE (City) New Jersey (State or country)	
(Signature) Charles Liberman M. D. CHARLES LIBERMAN (Print or Type Name)		17 NAME OF FATHER John McLaughlin	
(Address) WINTHROP, MASS Date 7/14/1967		18 BIRTHPLACE OF FATHER (City) Ireland (State or country)	
6 Winthrop Winthrop Place of Burial or Cremation (City or Town)		19 MAIDEN NAME OF MOTHER Ellen Tierney	
DATE OF BURIAL July 17, 1967		20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)	
7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley		21 Informant Margaret McLaughlin (Address) 26 Locust St., Winthrop	
ADDRESS Winthrop, Mass		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Philip G. Vitagliano (M.D.) (Signature of Agent of Board of Health or other) Director of Public Health 7/17/67 (Official Designation) (Date of Issue of Permit)	
Received and filed John J. O'Maley 19.....			
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

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance 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

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP, MASS.
(City or Town making this return)SUFFOLK
(County)WINTHROP
(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 148

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 JOSEPHINE DOBSON

(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. 2 EDGAR TERRACE.,

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 July 13 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 1966, to June 15 1967
I last saw him alive on June 14 1967, death is said to
have occurred on the date stated above, at 5:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

Due To (b) Carcinoma of breast

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Pathology examination

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) H. S. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Cheshire St. Date July 13 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 18, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed

JUL 17 1967

John A. Clark

(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 Samuel Dobson (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 Housewife (Kind of work done during most of working life)

14 Industry or Business: own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston Mass
(State or country)

17 NAME OF FATHER William Mulloy

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Adelaide Crandall

20 BIRTHPLACE OF MOTHER (City) East Boston Mass
(State or country)

21 Informant Zita Fulham

(Address) 33 Orlando Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip A. Vitagliano (mek)
(Signature of Agent of Board of Health or other)Director of Public Health
(Official Designation)

(Date of Issue of Permit) 7/17/67

File for 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,
pneumonia, 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
disease condition given
in (a).

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.

SUFFOLK

(County)

WINTHROP

(City or Town)

No.

WINTHROP COMMUNITY HOSPITAL

BABY GIRL DUVAL

2 NAME OF FETUS
(if given)The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCERTIFICATE OF FETAL DEATH
(STILLBIRTH)To be filed for burial permit with
Board of Health or its Agent.

Registered No. 149

St. } (If death occurred in a hospital or institution
give its NAME instead of street and number)

3 DATE OF DELIVERY 7/17/67

(Month) (Day) (Year)

4 SEX
Male.....Female ☒.....Undetermined.....5 COLOR (if
determined) W6 THIS BIRTH (Check one)
Single ☒ Twin.....Triplet.....7 IF MULTIPLE BIRTH, BORN:
1st.....2nd.....3rd.....8 FULL NAME
FATHER ERNEST H. DUVAL14 MAIDEN NAME GLORIA FARREN
PRESENT NAME GLORIA DUVAL9 RESIDENCE, NO. 169 BARTLT. RD STREET
CITY OR TOWN WINTHROP STATE MASS15 RESIDENCE, NO. 169 BARTLT. RD. STREET
CITY OR TOWN WINTHROP STATE MASS10 COLOR OR WHITE 11 AGE AT TIME OF 38
RACE THIS DELIVERY (Years)16 COLOR WHITE 17 AGE AT TIME OF 38
RACE THIS DELIVERY (Years)12 PLACE OF BIRTH CHELSEA, MASSACHUSETTS
(City or Town) (State or country)18 PLACE OF BIRTH WINCHESTER, MASSACHUSETTS
(City or Town) (State or country)

13 OCCUPATION MANAGER

19 INFORMANT ERNEST H. DUVAL (HUSBAND)

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) 6(a) How many children are
now living? 6(b) How many children were
born alive but are now
dead? 0(c) How many previous fetal
deaths of ANY gestation
age? 021 LENGTH OF PREGNANCY 38
.....completed weeks22 WEIGHT OF FETUS
5 Lb. 10 Oz.
(or.....Grams)23 WHEN DID FETUS DIE?
Before Labor ☒ During Labor
or Delivery.....Unknown.....24 AUTOPSY No ☒
Yes.....

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Premature Separation of Placenta

Due To (b)

Due To (c)

OTHER SIGNIFICANT
CONDITIONS none26 Winthrop Cem Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 17, 196727 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop St. Winthrop

Received and filed JUL 17 1967

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 1:10 A M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

A. Paul Der Hagopian M.D.
(PRINT OR TYPE SIGNATURE)

Address 39 WARY A - CHLSEA Date 7-17-67 19.....

I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano (13)
(Signature of Agent of Board of Health or other)Dir. of Public Health 7/17/67
(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.

FORM R-301

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. 150

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 Patterson, Mabelle C. (Ripley)
(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. 10 Glen Road St. Saugus

(City or town and State)

Length of stay: In place of death. 21 years. months. days. In place of residence. 25 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 18 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased, from
JUNE 29, 1967, to JULY 18, 1967
I last saw her alive on JULY 18, 1967, death is said to
have occurred on the date stated above, at 2:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACT

INTERVAL
BETWEEN
ONSET AND
DEATH

6 HRS.

Due To (b) ARTERIO-SCLEROTIC HEART

Due To (c) CONGESTIVE FAILURE

BUNDLE BRANCH BLOCK

OTHER SIGNIFICANT CONDITIONS ARTERIITIS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL + EKG

5 Was disease or injury in any way related to occupation of deceased? No

(Signature) Myron N. King, M. D.

(Address) 549 LINCOLN AVE. Date 7/18/67

Woodlawn Everett

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 21 1967

7 NAME OF FUNERAL DIRECTOR Bisbee & Son

ADDRESS 549 Lincoln Ave. Saugus

Received and filed JUL 21 1967

John A. Clark

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F. 9 COLOR W. 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 William A. Patterson
(Husband's name in full)12 AGE 82 Years 4 Months 8 Days If under 24 hours
Hours Minutes13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. none

16 BIRTHPLACE (City) Revere Mass.
(State or country)

17 NAME OF FATHER William A. Ripley

18 BIRTHPLACE OF FATHER (City) C.N.B.L.
(State or country)

19 MAIDEN NAME OF MOTHER Adalaide C. Thomas

20 BIRTHPLACE OF MOTHER (City) C.N.B.L.
(State or country)

21 Informant Robert G. Tillson

(Address) 24 Houston Ave. Wakefield

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip H. Vitagliano
(Signature of Agent of Board of Health or other)Dis. of Public Health 7/21/67
(Official Designation) (Date of Issue of Permit)do not enter
more than one
cause for each
of (a), (b) and (c)This does not mean
mode of dying,
such as heart failure,
pneumonia, etc. It means
the disease, or compli-
cations which caused
death.Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.Conditions contrib-
uting to death but not
related to the terminal
disease condition given
(a).

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

SUFFOLK

(County)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 151

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 Sylvia H. Korvek (Heino)
(If deceased was a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence, No. 86 Bowdoin St.
(Usual place of abode)St. Winthrop
(City or town and State)

Length of stay: In place of death, years, months, 7 days. In place of residence 12 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7 20 67
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
7-20-67, 1967, to 7-20-67, 1967
I last saw her alive on 7-20-67, 1967, death is said to
have occurred on the date stated above, at 12:30 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CIRRHOSIS LIVER

INTERVAL
BETWEEN
ONSET AND
DEATH

8 MO

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) A. N. CAPLAN MD, M. D.

(Print or Type Name)

(Address) 156 RIVINGTON ST. BOSTON 7-20-67

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 7-24-1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop, Mass.

Received and filed July 21, 1967

John A. Clark

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Stanley A. Korvek
(Husband's name in full)12 AGE 51 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. 012-14-2098

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF FATHER Henevy Heino

18 BIRTHPLACE OF FATHER (City) - -
(State or country) Finland

19 MAIDEN NAME OF MOTHER Impi Satanna

20 BIRTHPLACE OF MOTHER (City) - -
(State or country) Finland21 Informant Stanley A. Korvek
(Address) 86 Bowdoin St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip H. Vitagliano
Signature of Agent of Board of Health (or other)
Dir. of Public Health 7/21/67
(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

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSuffolk
(County)Winthrop
(City or Town making this return)

PLACE OF DEATH

Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 152

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Mary Babson (Covell)
(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. 6 Wave Way
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 23 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased, from
....., 19....., to..... JULY 23, 1967
I last saw him on JULY 23, 1967, death is said to
have occurred on the date stated above, at 9:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR Hemorrhage
(b) ARTERIO-SCLEROTIC HEART DIS. 5 YRS.
(c) HYPERTENSIVE HEART DIS. 5 YRS.INTERVAL
BETWEEN
ONSET AND
DEATH
3 DAYSOTHER SIGNIFICANT CONDITIONS CARCINOMA OF LEFT
BREAST 1 YR.
12 YEARS 5 YRS.Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myron N. King M. D.

MYRON N. KING M.D.

(Address) 122 PLUMSTADT ST. WINTHROP, MASS. Date 7/23 1967

6 TIFERETH ISRAEL EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 24, 1967

7 NAME OF FUNERAL DIRECTOR ROBERT W. LeVINE

ADDRESS 1668 BEACON ST. BRLINE

Received and filed JUL 24 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of BENJAMIN BABSON
(Husband's name in full)12 AGE 85 Years. Months. Days If under 24 hours
Hours. Minutes13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: AT Home.

15 Social Security No.

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER Louis Covell

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER SARAH (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)21 Informant MANUEL SCOTCH
(Address) 6 WAVE WAY AVE WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip J. Maglione
Signature of Agent of Board of Health or other)
Off. of Public Health 7/24/67
(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
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).

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

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
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 lost.

Conditions contrib-
uting to death but not
related to the terminal
cause given
(a).

PLACE OF DEATH

Suffolk

(County)

Winthrop, Mass.

(City or Town)

No. Winthrop Community Hospital

Carl O. Prescott

2 FULL NAME. (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 118 Quincy Ave. St. Winthrop, Massachusetts
(City or town and State)

Length of stay: In place of death. 28 days. In place of residence. 40 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 28 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2/25/67 to JULY 28 1967

I last saw him alive on JULY 28, 1967, death is said to have occurred on the date stated above, at 7:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR HEMORRHAGE 2 DAYS

Due To (b) CARCINOMA of PROSTATE 10 YRS

Due To (c) metastasis to bone 4 mo

OTHER SIGNIFICANT CONDITIONS RHEUMATOID SCLEROTIC HEART DISEASE & CHRONIC KIDNEY FAILURE 6 mo

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & X-ray

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King M.D. M. D.

(Address) 222 Pleasant St. Date JULY 25 1967
Winthrop, Mass.6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 31, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUL 31 1967
John A. Clark (Registrar)

A TRUE COPY ATTEST:

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. 153

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED widowed
WIDOWED divorced
DIVORCED UNKNOWN11 If married, widowed, or divorced
HUSBAND of Freda R. Prescott (Reilly)
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 70 Years 9 Months 13 Days If under 24 hours
Hours Minutes13 Usual Occupation retired salesman
(Kind of work done during most of working life)

14 Industry or Business: H. P. Hood Co.

15 Social Security No. 023-09-1810

16 BIRTHPLACE (City) Nashua
(State or country) New Hampshire

17 NAME OF FATHER Clifford H. Prescott

18 BIRTHPLACE OF FATHER (City) Westford
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Augusta E. Downing

20 BIRTHPLACE OF MOTHER (City) Dunstable
(State or country) Massachusetts

21 Informant Bruce R. Prescott

(Address) 50 Summit Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (max)
(Signature of Agent of Board of Health or other)
Director of Public Health (Date of Issue of Permit) 7/31/67
(Official Designation)

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

The Commonwealth of Massachusetts

MIDDLESEX

(County)

MALDEN

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Malden

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 154

No. MALDEN HOSPITAL

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ERMENAGILDA SACCOCCIO

(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. 90 MAIN

St. WINTHROP, MASS

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 3.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 31 1967

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-5 1967, to 7-31 1967.

I last saw him alive on 7-31 1967, death is said to have occurred on the date stated above, at 549 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hepatic failure

INTERVAL
BETWEEN
ONSET AND
DEATH

3 mos

(b) Due To Generalized Carcinomatosis

(c) Due To BREAST Adenoca (left)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Repeated operations

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Salvatore R. Traina, M. D.

SALVATORE R. TRAINA

(Print or Type Name)

(Address) 155 HIGH ST Date 7-31 1967

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG 3 1967

7 NAME OF FUNERAL DIRECTOR DIPIETRO VAZZA
11 HENRY ST, EAST BOSTON
ADDRESS

Received and filed AUG 2 1967

 Haibon J. Schneideman (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 ANTHONY SACCOCCIO
(Husband's name in full)

12 AGE 52 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 BOSTON PUBLIC SCHOOL

15 Social Security No. 011-01-0614

16 BIRTHPLACE (City) BOSTON MASS
(State or country)

17 NAME OF FATHER MICHELE BRUNO

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER MARIA DIESE

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)21 Informant ANTHONY SACCOCCIO
90 MAIN 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
 Public Health #47778 8/2/67
 (Official Designation) (Date of Issue of Permit)

 e 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
 mode of dying,
 of heart failure,
 hemio, etc. It means
 disease, or complica-
 tions which caused
 it.

 Conditions, if any,
 which gave rise to
 above cause (c),
 stating the under-
 lying cause last.

 Conditions contrib-
 uting to death but not
 related to the terminal
 disease condition given
 (c).

3 1967

TRUE COPY ATTEST:

Nathan J. Schneiderman

City Clerk

PLACE OF DEATH

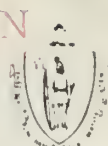
OUT OF TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON

155

(City or Town making this return)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 155285

N. MASSACHUSETTS GENERAL HOSPITAL (If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

2 FULL NAME FRANCES E. (TONRY) McQUILLEN (First Name) (Middle Name) (Last Name) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No 97 BEACH ROAD St. WINTHROP, MASSACHUSETTS (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. years 1 months 0 days. In place of residence 80 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 9 1967 (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 LEFT FEMUR;
HYPERTENSIVE ARTERIOSCLEROTIC
CARDIOVASCULAR DISEASE

5 Accident, suicide, or homicide (specify) ACCIDENT

Date and hour of injury MAY 10 1967

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? IN HOME (Specify type of place)

Manner of injury FALL (How did injury occur?)

Nature of injury FRACTURE OF LEFT FEMUR

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. (Print or Type Name)

(Address) 25 SHATTUCK ST. Date JUNE 10 1967

7 WINTHROP WINTHROP (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL JUNE 12 1967

8 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS 20 WINTHROP ST WINTHROP, MASS

Received and filed JUN 13 1967

A TRUE COPY ATTEST. (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX FEMALE 10 COLOR WHITE 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 GEORGE J. McQUILLEN (Husband's name in full)

13 AGE 88 Years 0 Months 0 Days If under 24 hours Hours Minutes

14 Usual Occupation: HOME MAINTENANCE (Kind of work done during most of working life)

15 Industry or Business: HOME

16 Social Security No. 017-40-2994

17 BIRTHPLACE (City) EAST BOSTON MASS. (State or country)

18 NAME OF FATHER JOHN TONRY

19 BIRTHPLACE OF FATHER (City) IRELAND (State or country)

20 MAIDEN NAME OF MOTHER FRANCES SKEERY

21 BIRTHPLACE OF MOTHER (City) IRELAND (State or country)

22 Informant GEORGE J. McQUILLEN (Address)

19 FRAGEE AVE, MALBORO, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

E10261 (Official Designation) 6/11/67 (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-9-63-936348

NOTE: CHAPTER 17, AC

18 1967

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

AUG 1 8



OFFICE OF THE
WINCHESTER

FORM R-301

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 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).

OUT - OF - TOWN

Suffolk
(County)

Boston
(City or Town)

PLACE OF DEATH

No. U. S. Public Health Service Hospital

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

BOSOTN 156
(City or Town making this return)

Registered No.

2 FULL NAME James Charles Walsh
(If deceased is a married, widowed or divorced woman, give also maiden name)

(If death occurred in a hospital or institution,
give its NAME in full or street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAVE) NO

(a) Permanent Residence. No. 235 Bowdoin

St. Winthrop, Mass.

(City or town and State)

Length of stay. In place of death 0 years 0 months 4 days. In place of residence 43 months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 19, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 15, 1967 to June 19, 1967
I last saw him alive on June 19, 1967 death is said to
have occurred on the date stated above, at 4:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Severe diabetic acidosis with hypokalemia.

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS: 1. Pulmonary congestion & edema, secondary to CHF. 2. Fatty infiltration of pancreas

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) Alvin Blumberg, M. D.

(Print or Type Name)
Alvin Blumberg, M. D.

(Address) USPSH, Boston, Mass. Date Jun 19, 1967

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 22, 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed

JUN 22 1967

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

11 If married, widowed or divorced
HUSBAND of CLARA M. SHEEHAN
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 68 Years Months Days 13 Usual Occupation FISH CUTTER.
(Kind of work done during most of working life)

14 Industry or Business FISH PIER.

15 Social Security No. 025-03-4797

16 BIRTHPLACE (City) SOUTH BOSTON
(State or country) MASS

17 NAME OF FATHER THOMAS WALSH

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country)

19 MAIDEN NAME OF MOTHER MARY POWERS

20 BIRTHPLACE OF MOTHER (City) N. F.
(State or country)

21 Informant CLARA M. WALSH
(Address) 235 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:

7. P. Maca E 10607
(Signature of Agent of Board of Health or other)

(Official Designation) June 20, 1967
(Date of Issue of Permit)

JUN 18 1967

A TRUE COPY ATTEST:

William J. Lee
City Registrar

2017

12



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.

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PLACE OF DEATH

Norfolk

(County)

Wrentham

(City or Town)

No. Wrentham State School2 FULL NAME Thomas Edward Kennedy

(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 MarshallSt. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 7 years 10 months 0 days. In place of residence 7 years 10 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1, 1967

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
January 19 64 to July 1 67I last saw him alive on July 1 67, death is said to
have occurred on the date stated above, 2.20 a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Meningoencephalomyelitis 6 days

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Phenylpyruvic Oligophrenia 15 yrs
Mental deficiency-severe lifeWas autopsy performed? noWhat test confirmed diagnosis? Physical signs5 Was disease or injury in any way related to occupation of deceased no
If so, specify(Signature) Edward K. Pearson, M. D.(Address) Wrentham, Mass. Date 7-1 676 Winthrop Cemetery, Winthrop

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL July 5 677 NAME OF FUNERAL DIRECTOR Maurice W. Kirby Funeral HomeADDRESS 210 Winthrop St., Winthrop, Mass.Received and filed AUG 24 1967 19

(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

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 15 Year 6 Months 1 Days

If under 24 hours

.....Hours.....Minutes

13 Usual

Occupation Resident of Wrentham State School

(Kind of work done during most of working life)

14 Industry
or Business: None15 Social Security No. None16 BIRTHPLACE (City) Washington
(State or country) D.C.

17 NAME OF

FATHER

Richard M. KennedyP
A
R
E
N
T
S

18 BIRTHPLACE OF

FATHER (City) East Boston(State or country) Mass.

19 MAIDEN NAME

OF MOTHER

Marie C. Ward

20 BIRTHPLACE OF

MOTHER (City) Newark(State or country) New Jersey21 Informant Records of Wrentham State School(Address) Wrentham, Mass.

A TRUE COPY

ATTEST: George Stoney

(Registrar of City or Town where death occurred)

DATE FILED July 7, 1967 19

MARGIN RESERVED FOR BINDING

WRITE 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

.....

AUG 24 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

COPY OF
 CERTIFICATE OF DEATH

Registered No. 424

Boston Hospital for Women-Parkway Division
 No. _____ St. (Give its NAME instead of street and number)

2 FULL NAME **Felicia Frazier (Kwiatowski)**
 (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. **59 Lewis Avenue** **Winthrop, Mass.**
 (City or town and State)

Length of stay: In place of death **21** years **16** months **21** days. In place of residence **16** years **16** months **21** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **July 5, 1967**
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 11, 1967 to **July 5, 1967**
 I last saw him alive on **July 5, 1967** death is said to
 have occurred on the date stated above, at **7:45 p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Disseminated Carcinoma of
 (a) **Cervix**

Due To
 (b)
 Due To
 (c)

OTHER
 SIGNIFICANT
 CONDITIONS

Was autopsy performed? **no**
 What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify

(Signature) **David S. Bard**
245 Pond Ave.

(Address) **Brookline, Mass.** Date **July 5, 1967**

Winthrop Cemetery-Winthrop, Mass.

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 8, 1967**

7 NAME OF FUNERAL DIRECTOR **Ernest P. Caggiano**
117 Winthrop St.
Winthrop, Mass.
 ADDRESS

Received and filed **SEP 1 1967**

(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 **William H. Frazier**
 (Give maiden name of wife in full)

(or) WIFE of _____
 (Husband's name in full)

12 **51** **1** **5** Days If under 24 hours
 AGE Years Months Days 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) **Chelsea**
 (State or country) **Mass.**

17 NAME OF FATHER **Paul Kwiatowski**

18 BIRTHPLACE OF FATHER (City) **Poland**
 (State or country)

19 MAIDEN NAME OF MOTHER **Helen (cannot be learned)**

20 BIRTHPLACE OF MOTHER (City) **Poland**
 (State or country)

William H. Frazier

21 Informant **59 Lewis Ave.**
 (Address) **Winthrop, Mass.**

A TRUE COPY

ATTEST: **Thomas F. Frazier**
 (Registrar of City or Town where death occurred)

DATE FILED **July 6, 1967**

MARGIN RESERVED FOR BINDING
 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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

SEP 1 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

Essex
(County)Danvers
(City or Town)COPY OF
CERTIFICATE OF DEATH

Registered No. _____

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give NAME instead of street and number)2 FULL NAME William H. McGillicuddy
(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) Perman. residence. No. 39 Pico Avenue 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 29, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
June 24 1967 to July 29 1967
I last saw him alive on July 29 1967 death is said to
have occurred on the date stated above, at 6:20 p.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia(b) Nephrosclerosis 1 years(c) Generalized arteriosclerosis 1 yrs.OTHER SIGNIFICANT CONDITIONS Diabetes mellitus 1 mos.Was autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory5 Was disease or injury in any way related to occupation of deceased?
If so, specify _____(Signature) Willard M. Hausman, M. D.(Address) Hathorne, Mass. Date 7/29/676 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)DATE OF BURIAL August 1 19677 NAME OF FUNERAL DIRECTOR O'Maley Funeral HomeADDRESS Winthrop, Mass.Received and filed AUG 15 1967 1967

(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 widowed11 If married, widowed, or divorced
HUSBAND of Mary Harron
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)12 AGE 82 years 5 months 29 days If under 24 hours
Hours Minutes13 Usual Occupation: Meat Salesman
(Kind of work done during most of working life)

14 Industry or Business: _____

15 Social Security No. 023-01-718116 BIRTHPLACE (City) Boston
(State or country) Massachusetts17 NAME OF FATHER Daniel E. McGillicuddy18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.19 MAIDEN NAME OF MOTHER Catherine Connolly20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.21 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.A TRUE COPY James J. Toomey
ATTEST: _____
(Registrar of City or Town where death occurred)DATE FILED August 7 1967

MARGIN RESERVED FOR BINDING

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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

1117 90

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

COPY OF
 CERTIFICATE OF DEATH

Registered No. 1114

{(If death occurred in a hospital or institution,
 St. { give its NAME instead of street and number)

No. Holy Ghost Hospital

2 FULL NAME: Norma Patrick
 (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. 455 Shirley St. Winthrop, Mass.
 (City or town and State)

Length of stay: In place of death... years 2 months... days. In place of residence 40 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 29, 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
 May 29 67, to July 29 67
 I last saw him alive on July 28 67 death is said to
 have occurred on the date stated above, at 7:15 AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia
 Due To Reticulum Cell Sarcoma
 (b) Right Parietal Lobe of Brain
 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

(Signature) William H. Garvin, Jr., M.D., M. D.
 " " " " " "

(Address) Holy Ghost Hosp. Date 7/29/1967

6 Puritan Lawn Peabody
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 1 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed SEP 6 1967

(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 68 Years 9 Months 21 Days If under 24 hours
 Hours Minutes

13 Usual Occupation: Piano Teacher
 (Kind of work done during most of working life)

14 Industry or Business: Self

15 Social Security No. 030-01-3379

16 BIRTHPLACE (City) Keeney
 (State or country) New Hampshire

17 NAME OF FATHER Samuel Patrick

18 BIRTHPLACE OF FATHER (City) c.n.b.l.,
 (State or country) Vermont

19 MAIDEN NAME OF MOTHER Susan Applin

20 BIRTHPLACE OF MOTHER (City) c.n.b.l.,
 (State or country) Vermont

21 Informant Lewis Patrick
 (Address) 8 Garrison St., Boston, Mass.

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

July 31, 1967

19

MARGIN RESERVED FOR BINDING
 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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Chelsea 161
 (City or Town making this return)

STANDARD
 CERTIFICATE OF DEATH

Registered No. 333

1 PLACE OF DEATH
 Suffolk (County)
 Chelsea (City or Town)

No. Soldiers' Home Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

Nicolas F. TALLINI (Also known as) PHYSICIAN - IMPORTANT

2 FULL NAME Nicholas F. Tallini, Frank N. Tallini (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. 40 Ocean 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 30 19 67 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6:15, 19 67, to 7:30, 19 67

I last saw him alive on 7/30, 19 67, death is said to have occurred on the date stated above, at 9:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral embolism. (Cerebral embolism)

(b) Due To Cerebrovascular disease (Cerebrovascular disease)

(c) Due To (Cerebrovascular disease)

OTHER SIGNIFICANT CONDITIONS Bronchogenic Cyst (Bronchogenic cyst)

Was autopsy performed? No Clinical
 What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
 If so, specify

(Signature) R. Zelazny, M.D.

(Address) Soldiers' Home Hospital, 7/30 19 67
 Winthrop Cem. Winthrop, Mass.

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 2 19 67

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano & Son

ADDRESS 147 Winthrop St., Winthrop, Mass.

Received and filed Aug 3 19 67

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 Mary Wedderspoon (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years 7 Months 25 Days If under 24 hours Hours Minutes

13 Usual Occupation Salesman (Kind of work done during most of working life)

14 Industry or Business Not known

15 Social Security No. 339-05-0655

16 BIRTHPLACE (City) (State or country) Italy

17 NAME OF FATHER Gennaro Tallini

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Cesera Tebaffe

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Hospital Record

(Address) 91 Crest Ave, Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Agent July 31, 1967

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

9/6/18

DATE OF DISCHARGE.....

2/4/19

RANK, RATING.....

Pvt.

ORGANIZATION AND OUTFIT.....

U.S.A. - Adj. SGT. Personnel Sect. Army @ V. 77

SERVICE NUMBER.....

4902870.

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.

A TRUE COPY ATTEST:

John P. Doherty

City Clerk

AUG 21 '67 AM



CITY OF CHELSEA
MASS.



The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 162

Suffolk

(County)

Winthrop

(City or Town)

No. 63 Summit Ave.,

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Walter W. Corcoran

(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. 63 Summit Ave.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 20 years months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 1, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan 1, 1964, to Aug 1, 1967
I last saw him alive on Aug 1, 1967, death is said to
have occurred on the date stated above, at 11:47 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

INTERVAL
BETWEEN
ONSET AND
DEATH

1 day

Due To Hypertensive Arterio
(b) Sclerotic Heart Disease

1 yr.

Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

None

Was autopsy performed?

No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.

CHARLES A. LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS. Date 8/11/67

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 4, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed AUG 3 1967

(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 Eleanor Barter
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 44

Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

Salesman

(Kind of work done during most of working life)

14 Industry

or Business:

Shoe Business

15 Social Security No.

031-22-0979

16 BIRTHPLACE (City)

Dover

(State or country)

New Hampshire

17 NAME OF
FATHER

Walter Corcoran

18 BIRTHPLACE OF

FATHER (City)

C.B.L.

(State or country)

19 MAIDEN NAME

OF MOTHER

Johanna Kenney

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21

Informant
(Address)

Eleanor Corcoran

63 Summit Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

Philip J. Vagliasino Jr.
Dir. of Public Health
(Official Designation)8/3/67
(Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
b) and (c)is, if any,
ve rise to
ause (a),
he under-
ause last.ions contrib-
ath but not
the terminal
dition givenChapter 137,
14, requires
at to print or
h cause or
death on
ificates, and
, Acts of
res Physi-
ent or type
signature.

6-925686

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....10-2-42

DATE OF DISCHARGE.....9-24-45

RANK, RATINGCoxswain

ORGANIZATION AND OUTFIT.....U.S. Navy

SERVICE NUMBER.....573 01 94

.....

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-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
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
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

WINTHROP

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 163

No. Winthrop Community Hospital

St. {at death occurred in a hospital or institution,
give its NAME instead of street and number}

2 FULL NAME HERBERT PERMATTEO
(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 WARL

(a) Permanent Residence. No. 69 LINCOLN ST., St. WINTHROP, MASS 02152
(City or town and State)

Length of stay: In place of death.....years.....months.....2 days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 2 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
7-31 1967 to 8-2 1967

I last saw him alive on August 1, 1967 death is said to
have occurred on the date stated above, at 6:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral vascular accident

(b) arterial sclerosis

(c)

OTHER SIGNIFICANT CONDITIONS myocardial infarction (old)
Brunner'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 NO

(Signature) [Signature], M. D.

147 WINTHROP ST (Print or Type Name)
(Address) WINTHROP Date 8-2 1967

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug 5 1967

7 NAME OF FUNERAL DIRECTOR Ernest Pagnano

ADDRESS 147 WINTHROP ST WINTHROP

Received and filed AUG 3 1967

John Clark (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 Cecile Perrier
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 61 Years 13 Months 13 Days If under 24 hours
Hours Minutes

13 Usual Occupation RETIRED INSURANCE MAN
(Kind of work done during most of working life)

14 Industry or Business MET LIFE INS.

15 Social Security No. 030-09-2998

16 BIRTHPLACE (City) REVERE
(State or country) MASS

17 NAME OF FATHER DOMENIC PERMATTEO

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER MARY STERBI

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant Cecile Permatteo
(Address) 69 LINCOLN 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:

Philip A. Vitagliano (make)
(Signature of Agent of Board of Health or other)

Director of Public Health 8/3/67
(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.

FORM R-301

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,
sthenia, 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
cause given
(a).

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 42 Loring Road

2 FULL NAME Lottie S. Keating
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 42 Loring Road

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 August 5, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
June 19, 1967 to Aug 5, 1967
I last saw him alive on Aug 1, 1967 death is said to
have occurred on the date stated above, at 6 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac renal failure 2 months

(b) Gen. arteriosclerosis 2 yrs.

(c) Due To

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No.
What test confirmed diagnosis? Clinical.5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signature) Charles M. Meloni, M. D.

CHARLES M. MELONI
(Print or Type Name)

(Address) 45 Bay State Ave. Boston Date Aug 5, 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 7, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed August 7, 1967

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. 164

(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 Widowed
WIDOWED Divorced
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of James S. Keating
(Husband's name in full)12 AGE 75 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 L. Smith

18 BIRTHPLACE OF FATHER (City) Germany
(State or country)

19 MAIDEN NAME OF MOTHER Julia Carney

20 BIRTHPLACE OF MOTHER (City) New Brunswick
(State or country)21 Informant Beverly Keating
(Address) 42 Lorind Road WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip H. Vitagliano (M.D.)
(Signature of Agent of Board of Health or other)
Director of Public Health
(Official Designation) 8/7/67
(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.

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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

Winthrop, Mass.

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No.

165

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 Edith Sampson (Boudreau)
(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

146 Princeton St.

East Boston, Mass.

(a) Permanent Residence. No. _____ St. _____

(City or town and State)

Length of stay: In place of death.....years.....months 21 days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 5, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 1961 to August 5, 1967

I last saw her alive on Aug. 5, 1967, death is said to have occurred on the date stated above, at 10:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic and(b) Rheumatic Heart Disease

(c) _____

INTERVAL
BETWEEN
ONSET AND
DEATH

20 yrs.

OTHER SIGNIFICANT CONDITIONS Cirrhosis of liver
Diabetes Mellitus10 yrs.
5 yrs.

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 M.D.
(Print or Type Name)

(Address) 238 Shore Drive Date 8/5/1967

Winthrop, Mass.

Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 9, 19677 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATHADDRESS East BostonReceived and filed August 8, 1967John A. Clark

(Registrar)

A TRUE COPY ATTEST:

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 Leo W. Sampson (Husband's name in full)

12 AGE 67 Years..... Months..... Days If under 24 hours
Hours..... Minutes

13 Usual Occupation Housework
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No. CAVAL16 BIRTHPLACE (City) (State or country) CANADA17 NAME OF FATHER Simon Boudreau

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER LOUISE FOUGERE

20 BIRTHPLACE OF MOTHER (City) (State or country) CANADA

21 Informant Louise B. Murphy(Address) 274 HAURE 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:

Philip H. Vitagliano (M.D.)

(Signature of Agent of Board of Health or other)

Director of Public Health

(Official Designation)

8/8/67

(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.

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FORM R-301

File 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
of (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
above cause (a),
stating the under-
lying cause last.

Conditions contrib-
ing 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)
WINTHROP
(City or Town)

WINTHROP COMMUNITY HOSPITAL
No. DiGiambattorio St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

MARAA (DIGIAMBITTORIO) CHIULLI
2 FULL 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. 20 HERMON ST. 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 15 years 15 months 15 days.

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH <u>AUGUST 8, 1967</u> (Month) (Day) (Year)	8 SEX <u>FEMALE</u>	9 COLOR <u>WHITE</u>	10 SINGLE (write the word) <u>MARRIED</u> MARRIED WIDOWED DIVORCED UNKNOWN
4 I HEREBY CERTIFY That I attended deceased from <u>JAN 1964</u> to <u>AUG 8, 1967</u> I last saw him alive on <u>AUG 8, 1967</u> , death is said to have occurred on the date stated above, at <u>1000</u> m.	11 If married, widowed, or divorced HUSBAND of <u>Sabatino Chiulli</u> (Give maiden name of wife in full) (or) WIFE of <u>Sabatino Chiulli</u> (Husband's name in full)		
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute</u> (b) <u>Hypertensive Arteriosclerosis</u> (c) <u>Heavy Disease</u>	12 <u>70</u> AGE Years Months Days If under 24 hours Hours Minutes		
OTHER SIGNIFICANT CONDITIONS <u>Hypothyroidism</u>	13 Usual Occupation <u>Housewife</u> (Kind of work done during most of working life)		
Was autopsy performed? <u>No</u> What test confirmed diagnosis? <u>Clinical</u>	14 Industry or Business <u>At home</u>		
5 Was disease or injury in any way related to occupation of deceased? <u>No</u> If so, specify	15 Social Security No. <u>029-05-60958</u>		
(Signature) <u>Charles Liberman</u> M. D. <u>CHARLES LIBERMAN</u> (Print or Type Name) (Address) <u>WINTHROP, MASS.</u> Date <u>8/8/67</u>	16 BIRTHPLACE (City) <u>Italy</u> (State or country)		
6 <u>Winthrop Cemetery Winthrop</u> Place of Burial or Cremation (City or Town) DATE OF BURIAL <u>August 11</u> 19 <u>67</u>	17 NAME OF FATHER <u>Michael DiGiambattorio</u>		
7 NAME OF FUNERAL DIRECTOR <u>Vincent R. Rapino</u> ADDRESS <u>9 Chelsea St., C. Boston, Mass.</u>	18 BIRTHPLACE OF FATHER (City) <u>Italy</u> (State or country)		
Received and filed <u>August 10, 1967</u> <u>John A. Clark</u> (Registrar)	19 MAIDEN NAME OF MOTHER <u>Adeline Aniello</u>		
A TRUE COPY ATTEST:	20 BIRTHPLACE OF MOTHER (City) <u>Italy</u> (State or country)		
	21 Informant <u>Sabatino Chiulli (husband)</u> (Address) <u>20 Hermon St., Winthrop, Mass.</u>		
	I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: <u>Philip A. Vitagliano (mek)</u> (Signature of Agent of Board of Health or other) <u>Director of Public Health</u> 8/10/67 (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.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

In giving
OF DEATH

do not enter
more than one
use for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
a, etc. It means
cause, or compli-
c which caused

itions, if any,
h gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
go death but not
te to the terminal
as condition given

Chapter 137,
1954, requires
ans to print or
e he cause or
se of death on
th certificates.

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

WINTHROP

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 167

No. VIKING NURSING HOME (If death occurred in a hospital or institution,
St. [give its NAME instead of street and number])

2 FULL NAME FRANK R. RINI } **PHYSICIAN - IMPORTANT**
(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 East Newton St. Boston
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 1 months 50 days. In place of residence 50 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 8 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY. That I attended deceased from
July 20, 1967 to Aug 8, 1967

I last saw him alive on Aug 6, 1967, death is said to
have occurred on the date stated above, at 10:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized Carcinomatosis

INTERVAL
BETWEEN
ONSET AND
DEATH
2 Mos.

Due To Carcinoma of Prostate
(b) 1 1/2 yrs.

Due To NONE
(c)

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) M. Traustman, Jr., M. D.
(Address) 73 BARTLETT RD. Date Aug 8, 1967

6 St. Michaels WINTHROP
Place of Burial or Cremation Rosindale (City or Town)
DATE OF BURIAL Aug 12 1967

7 NAME OF FUNERAL DIRECTOR Dello Russo Fun. Ser.
ADDRESS 306 MAIN ST. Medford

Received and filed AUG 10 1967 19
John J. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR Caucasian 10 SINGLE (write the word) Married
MARRIED WIDOWED or DIVORCED Divorced

10a If married, widowed, or divorced
HUSBAND of Elizabeth (Paul)
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years 0 Months 0 Days If under 24 hours
Hours 0 Minutes

13 Usual Occupation: Cab DRIVER
(Kind of work done during most of working life)

14 Industry or Business: Ralph Peters, Boston

15 Social Security No. 025-03-6781

16 BIRTHPLACE (City) Boston
(State or country)

17 NAME OF FATHER Emilio

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Irma Raviati

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mrs. Priscilla D'Onofrio
(Address) 916 - Hyde Park Ave, Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (MCK)
(Signature of Agent of Board of Health or other)

Director of Public Health 8/10/67
(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 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 in 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

M R-303

ed for burial permit
Board of Health
its Agent.

OR TYPE THE CAUSE OF DEATH IN PLAIN TERMS. 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-9-63-936248

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)

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No. 168

No. Waters off Winthrop

(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

2 FULL NAME JOSEPH J. WALSH
(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. 201 Pleasant Street, Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. 19 years. months. days. In place of residence 19 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 9, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Asphyxia due to drowning. Senility
Carcinoma of prostate.

5 Accident, suicide, or homicide (specify) Presumably accidental
Date and hour of injury August 9, 1967

IF ACCIDENTAL, was injury causally related to the death?

Where did Winthrop, Mass.
Injury occur? (City or town and State)

Did injury occur in or about home, or farm, in industrial place, or in public place? Waters off Winthrop.

Manner of Accidental fall into water.
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. DeGore, M.D.
(Print or Type Name)

(Address) Boston Date 8/9 67

7 Holy Cross, Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 12, 1967

8 NAME OF FUNERAL DIRECTOR William J. Killion

ADDRESS 1 Sprague St. Revere, Mass.

Received and filed August 11, 1967

A TRUE COPY ATTEST:

(Registrar)

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 Katherine McNeil
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 90 Years 0 Months 0 Days If under 24 hours Hours Minutes

14 Usual Occupation: Motor car (electric) oper.
(Kind of work done during most of working life)

15 Industry or Business: Street railway transit

16 Social Security No. 024-10-4773-A

17 BIRTHPLACE (City) Charlottetown, P.E.I.
(State or country)

18 NAME OF FATHER John Walsh

19 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

20 MAIDEN NAME OF MOTHER Margaret Carroll

21 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

22 Informant John M.J. Walsh
(Address)

201 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:

Philip G. Vitagliano (Mck)
(Signature of Agent of Board of Health or other)

Director of Public Health 8/11/67
(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.)"

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 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).

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. 169

1 PLACE OF DEATH
Suffolk
(County)
Winthrop
(City or Town)



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 Maude Evelyn Hallett (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. 58 Otis Street St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years 18 months.....days. In place of residence 60 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 14 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JULY 31, 1967, to AUG 14, 1967
1 last saw her alive on AUG 14, 1967 death is said to
have occurred on the date stated above, at 5:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

(b) CARCINOMA OF BREAST

(c) ARTERIO-SCLEROTIC HEART DISEASE

OTHER
SIGNIFICANT
CONDITIONSHYPERNEPHROMA
SENILE DEMENTIA
DIABETES MELLITUSINTERVAL
BETWEEN
ONSET AND
DEATH

1 mo.

2 yrs

2 yrs

1 mo

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. Kinney, M. D.

(Print or Type Name) MYRON KINNEY MD

(Address) 222 ALEXANDER ST. Date 8/14 1967

WINTHROP, MASS.

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 16, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed August 16, 1967

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 Frank Parker Hallett

(Husband's name in full)

12 AGE 80 Years 1 Months 24 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. 002-05-6726

16 BIRTHPLACE (City) Somerville

(State or country) Massachusetts

17 NAME OF FATHER Albert Smith

18 BIRTHPLACE OF FATHER (City) Somerville

(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Nettie Carlo

20 BIRTHPLACE OF MOTHER (City) Somerville

(State or country) Massachusetts

21 Informant Mrs. William T. Kinney

(Address) 23 A. Taft Avenue

I HEREBY CERTIFY that a satisfactory standard certificate of death

Mass filed with me BEFORE the burial or transit permit was issued:

Philip A. Vitarbano (13)

(Signature of Agent of Board of Health or other)

Dir. of Public Health 8/16/67

(Official Designation)

(Date of Issue of Permit)

COVERTING FOR DR. H. GREENFIELD ON VACATION MEDICAL EXAMINER NOTIFIED—DECLINED JURISDICTION

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.

NOTE-170 C1, 5 F Ave

44

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

WINTHROP COMMUNITY HOSPITAL

Registered No. 170

 (If death occurred in a hospital or institution,
 St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

 2 FULL NAME ROSE (LURENSKY,) BOIARSKY
 (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. 110 LORING ROAD St. WINTHROP, MASSACHUSETTS
 (City or town and State)

 Length of stay: In place of death.....years.....months.....days. 17
 In place of residence: 12 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH AUGUST 15, 1967
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY That I attended deceased from
Jan 1957 to Aug. 15, 1967
 I last saw her alive on Aug. 15, 1967, death is said to

 have occurred on the date stated above, at 8:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular
 Due To Occlusion with left
 (b)

 Due To Hemiplegia
 (c)

 OTHER SIGNIFICANT CONDITIONS Hypertensive Arteriosclerosis 5 yrs
Heart Disease
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) Charles Liberman M. D.
CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS Date 8/15/1967
 6 KENNESSETH ISRAEL - WOBURN
 Place of Burial or Cremation (City or Town)
DATE OF BURIAL AUGUST 16, 1967
 7 NAME OF FUNERAL DIRECTOR ROBERT W. LEVINE
ADDRESS 1661 BEDFORD ST. BROOKLINEReceived and filed AUG 15 1967 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

 8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED WIDOWED
UNKNOWN

 11 If married, widowed, or divorced
 HUSBAND of

 (or) WIFE of BENJAMIN BOIARSKY
 (Give maiden name of wife in full)
 (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. UNKNOWN
 16 BIRTHPLACE (City).....
 (State or country) Russia

 17 NAME OF FATHER ELI BOIARSKY

 18 BIRTHPLACE OF FATHER (City).....
 (State or country) Russia

 19 MAIDEN NAME OF MOTHER HANNA (UNKNOWN)

 20 BIRTHPLACE OF MOTHER (City).....
 (State or country) Russia

 21 Informant DR. SAMUEL H. BOYER
(Address) 60 BROOKLINE ST. CHESTNUT
 I HEREBY CERTIFY that a satisfactory standard certificate of death was
 was filed with me BEFORE the burial or transit permit was issued:

Philip A. Votawianop
 (Signature of Agent of Board of Health or other)
Director of Public Health 8/15/67
 (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.

FORM R-301

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 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).

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. 171

No. Viking Nursing Home 142 Pleasant St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME. Joseph T Ratajczyk

(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. 68 Walnut

St. Chelsea

(City or town and State)

Length of stay: In place of death.....years 1 months 14 days. In place of residence 53 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 15 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
June 17 67, to August 15 67

I last saw him alive on August 13 1967, death is said to
have occurred on the date stated above, at 6:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia Terminal

INTERVAL
BETWEEN
ONSET AND
DEATH

3 Days

(b) Carcinoma of Lung

Months

(c) Due To

OTHER SIGNIFICANT CONDITIONS Metastatic Carcinoma
of Brain

Months

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 Gregorie, M. D.

(Address) 194 Washington Ave Date 8/15 1967

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 17 August 1967

7 NAME OF FUNERAL DIRECTOR Walter S Walata Jr

ADDRESS 125 Washington Ave Chelsea

Received and filed AUG 15 1967

A TRUE COPY ATTEST:

(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 Mary Saschuk
(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 General Laborer
(Kind of work done during most of working life)

14 Industry or Business Mystic Docks

15 Social Security No. 022 07 8640

16 BIRTHPLACE (City) Chelsea
(State or country) Mass

17 NAME OF FATHER Thomas Ratajczyk

18 BIRTHPLACE OF FATHER (City) Poland
(State or country)

19 MAIDEN NAME OF MOTHER Josephine Brill

20 BIRTHPLACE OF MOTHER (City) Poland
(State or country)

21 Informant Mrs Helen Cichonska

(Address) 208 Clark Ave Chelsea Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip S Vitagliano

(Signature of Agent of Board of Health or other)

Director of Public Health 8/15/67
(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.

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DATE OF DEATH

PLACE OF DEATH

INSTITUTION

RESIDENCE

SEX

SC

AGE

OCCUPATION

BIRTHPLACE

CITIZENSHIP

VETERAN

CAUSE OF DEATH

DIAGNOSIS

1. NAME OF DECEASED (TYPE OR PRINT)		A. (FIRST) William		B. (MIDDLE) Creswald		C. (LAST) Hughes		2. DATE (MONTH) (DAY) (YEAR) OF DEATH 8/17/67	
3. PLACE OF DEATH		A. COUNTY Hillsborough		B. CITY Manchester		C. CITY (GIVE ACTUAL TOWN OF RESIDENCE. NOT MAILING ADDRESS). TOWN Lowell		4. USUAL RESIDENCE (WHERE DECEASED LIVED. IF INSTITUTION, RESIDENCE BEFORE ADMISSION.) A. STATE Mass. B. COUNTY Middlesex	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED ☒ NEVER MARRIED ☐ DIVORCED ☐ WIDOWED ☐		8. DATE OF BIRTH (IN YEARS) 4/29/01		9. NAME OF HUSBAND OR WIFE (MARRIED NAME IF WIFE) Norma Ford	
10. AGE (IN YEARS) 66		11. DATE OF BIRTH (IN YEARS) 4/29/01		12. BIRTHPLACE (CITY OR TOWN, STATE) Liverpool, England		13. CITIZEN OF WHAT COUNTRY? USA		14. FATHER'S NAME William Hughes	
15. MOTHER'S MAIDEN NAME Thomasina Larmour		16. WAS DECEASED EVER IN U.S. ARMY OR FORCE? YES		17. SOC. SEC. NO. 011-01-2781		18. ADDRESS 718 Smyth Rd., Manchester, N.H.		19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)) PART I DEATH WAS CAUSED BY: Anemia, severe (DiGuglielmo's Syndrome) 2 Yrs. IMMEDIATE CAUSE (A)	
20. WAS AUTOPSY PERFORMED? YES ☒ NO ☐		21. PLACE OF INJURY (E. D., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)		22. DATE (MONTH) (DAY) (YEAR) (HOUR) (MIN.) 7/7/67		23. ADDRESS VAH, Manchester, N. H.		24. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass.	
25. FUNERAL DIRECTOR'S SIGNATURE Howard Reynolds, Winthrop, Mass.		26. DATE 8/21/67		27. NAME OF CEMETERY OR CREMATORY Winthrop Cem.		28. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass.		29. DATE 8/21/67	
30. SIGNATURE Roger H. Wright, M. D.		31. DATE 8/21/67		32. ADDRESS VAH, Manchester, N. H.		33. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass.		34. DATE 8/21/67	
35. SIGNATURE Roger H. Wright, M. D.		36. DATE 8/21/67		37. ADDRESS VAH, Manchester, N. H.		38. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass.		39. DATE 8/21/67	
40. SIGNATURE Roger H. Wright, M. D.		41. DATE 8/21/67		42. ADDRESS VAH, Manchester, N. H.		43. LOCATION (CITY, TOWN, OR COUNTY) (STATE) Winthrop, Mass.		44. DATE 8/21/67	

MEDICAL CERTIFICATION

CONDITIONS. IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I A.

Congestive heart failure.

21A. ACCIDENT SUICIDE HOMICIDE

21C. TIME OF INJURY

21D. INJURY OCCURRED WHILE AT WORK ☐ AT WORK ☐

21E. PLACE OF INJURY (E. D., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)

21F. CITY, TOWN OR LOCATION

21G. STATE

21H. ADDRESS

21I. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

21J. DATE

21K. ADDRESS

21L. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

21M. DATE

21N. ADDRESS

21O. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

21P. DATE

21Q. ADDRESS

21R. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

21S. DATE

21T. ADDRESS

21U. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

21V. DATE

21W. ADDRESS

21X. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

21Y. DATE

21Z. ADDRESS

21AA. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

21AB. DATE

21AC. ADDRESS

21AD. LOCATION (CITY, TOWN, OR COUNTY) (STATE)

AUG 22 1967 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

MARGIN RESERVED FOR BINDING

1	PLACE OF DEATH	Essex		KEVIN H. WHITE	Danvers
		(County)		SECRETARY OF THE COMMONWEALTH	(City or Town making this return)
		Danvers		DIVISION OF VITAL STATISTICS	
		(City or Town)		COPY OF	173
				CERTIFICATE OF DEATH	Registered No.
		No. Danvers State Hospital			{(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

2 FULL NAME Louis Kerimel (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so, specify (MCAR) No

(a) Permanent residence. No. 150 Locust St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months.....²⁹days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 17, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
July 18, 1967, to August 17, 1967
I last saw him alive on August 17, 1967 death is said to

have occurred on the date stated above, at 5:00p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Addison's disease

Due To	B. left adrenal gland	yrs.
(b)		

Due To Ulceration Esophagus ?

OTHER SIGNIFICANT CONDITIONS	Chronic pancreatitis Infarct of spleen	mos mos.
------------------------------------	---	-------------

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.

(Address) Hathorne, Mass. Date. 8/19/67

6 Woodlawn Crematory Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 21 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed **AUG 28 1967** 19

John A. Clark
(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 Lucienne Heurgue
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

AGE ¹² 74 Years 10 Months 14 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Jeweler (retired)
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. 010-09-9648

16 BIRTHPLACE (City) Binic
(State or country) France

17 NAME OF FATHER	Louis Kerimel
-------------------	---------------

18 BIRTHPLACE OF
FATHER (City).....
(State or country) France

19 MAIDEN NAME
OF MOTHER Marie Feuillet

20 BIRTHPLACE OF
MOTHER (City).....
(State or country) France

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY *D. J. Trimmer*

ATTEST: _____
(Registrar of City or Town where death occurred)

DATE FILED August 24 1967

100M-5-64-938000

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

AUG 28 '67 AM



CLERK OF THE TOWN CLERK
WINTHROP, MAINE

nd for burial permit
ard of Health
Agent.

STRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
se for each
, (b) and (c)

does not mean
ode of dying,
s heart failure,
a, etc. It means
eose, or compli-
which caused

itions, if any,
h gave rise to
e cause (o),
ng the under-
cause lost.

nditions contrib-
to death but not
to the terminal
condition given

1
PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. Cliff House Nursing Home

2 FULL NAME

AGNES M DRISCOLL
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 99 Winthrop St.,
(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

Length of stay: In place of death, years 2 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 19, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
July 10, 1946, to August 19, 1967.
I last saw her alive on August 19, 1967, death is said to
have occurred on the date stated above, at 7:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Arteriosclerotic & Hypertensive
Heart Disease

Due To Generalized Arteriosclerosis
(b) —
(c) —

OTHER
SIGNIFICANT
CONDITIONS

Diabetes Mellitus
PERNICIOUS ANEMIA

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. Frankenstein, Jr. M.D.
(Print or Type Name)

(Address) 73 Bartlett Rd., Winthrop, Mass.
Date: Aug 19, 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 23, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed AUG 22 1967

John A. Clear (Registrar)

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. 174

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

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 Maurice F. Driscoll
(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 Nicholas Fitzgerald

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Hannigan

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Dorothy Bowditch
(Address) 99 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:

Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)

Dir. of Public Health 8/22/67
(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.

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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.

FORM R-301

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.

175

No. Viking Nursing Home

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lorenzo R Cobos

(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. 19 Elm St

St.

Lynn 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 Aug 22 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Aug 18, 1967, to Aug 22, 1967.I last saw him on Aug 20, 1967, death is said to
have occurred on the date stated above, at 10:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

(b) Arteriosclerosis - gen

(c)

OTHER
SIGNIFICANT
CONDITIONS Empty Stomach
Senility

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 J. Regiore, M. D.

(Print or Type Name) Joseph J. Regiore

(Address) 194 Washington St Date 8-22 1967

6 Harmony Grove Salem Mass
XXXXXXX or Cremation (City or Town)

DATE OF BURIAL August 25 1967

7 NAME OF FUNERAL DIRECTOR Goodrich Funeral Home

ADDRESS 128 Washington St Lynn Mass

Received and filed AUG 23 1967

John A. Clark

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Bessie May Hassett
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 82 9 8 If under 24 hours
Years Months Days Hours Minutes13 Usual Occupation Retired
(Kind of work done during most of working life)

14 Industry or Business Elec Eng. Gen Elec R.W.

15 Social Security No. 024-16-5276-A

16 BIRTHPLACE (City) Bayamon
(State or country) Puerto Rico

17 NAME OF FATHER Gregorio Cobos

18 BIRTHPLACE OF FATHER (City) Salamanaca
(State or country) Spain

19 MAIDEN NAME OF MOTHER Marie Louise Cavanne

20 BIRTHPLACE OF MOTHER (City) Versailles
(State or country) France

21 Informant Marie C Reynolds

4307 42nd St Sunnyside Long Island N.Y.
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip E. Vitagliano (M.D.)

(Signature of Agent of Board of Health or other)

Director of Public Health

(Official Designation)

(Date of Issue of Permit) 8/23/67

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).

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.)

SOM-3-62-932695

PLACE OF DEATH

Middlesex (County)

Cambridge (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

176
Cambridge (City or Town making this return)

Registered No. 1247

No. Holy Ghost Hospital

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

2 FULL NAME Gladys Driscoll (Turner)
(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. 115 Winthrop
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....2.....months.....19.....days. In place of residence.....19.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1967
(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.)

Carcinoma of Sigmoid with Hydronephrosis, right
and Confluent Bronchopneumonia complicating

Fracture of Left Hip. Injury received
in Fall in Home Accident.

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury Sept. 5, 1966 at 8:30 A.M.

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? in home
(Specify type of place)

Manner of injury Accidental Fall
(How did injury occur?)

Nature of injury Fracture of Left Hip

While at work? No Was autopsy performed? YES

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) David C. Dow, M. D.

(Address) Cambridge, Mass. Date 8-25 1967

7 Winthrop Cem. Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 29, 1967

8 NAME OF FUNERAL DIRECTOR Ernest Plaggrano

ADDRESS 147 Winthrop St. Winthrop

Received and filed SEP 6 1967

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

12 If married, widowed, or divorced

HUSBAND of Harold E. Driscoll

(or) WIFE of (Give maiden name of wife, if married)
(Husband's name in full)

AGE 74 7 22 If under 24 hours
Years Months Days Hours Minutes

14 Usual Occupation Pharmacist
(Kind of work done during most of working life)

15 Industry or Business Drug Store
023-10-7989

16 Social Security No. Dorchester

17 BIRTHPLACE (City) New Brunswick
(State or country)

18 NAME OF FATHER Albert Turner

19 BIRTHPLACE OF FATHER (City) Dorchester
(State or country) New Brunswick

20 MAIDEN NAME OF MOTHER Eva (c.n.b.l.)

21 BIRTHPLACE OF MOTHER (City) Dorchester
(State or country) New Brunswick

22 Informant Harold E. Driscoll
(Address)

115 Winthrop St. Winthrop, Mass.

A TRUE COPY

ATTEST: Thomas Andre Damara
(Registrar of City or Town where death occurred)

DATE FILED Aug. 29, 1967

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

Danvers

(City or Town making this return)

FORM R-302



Essex

(County)

Danvers

(City or Town)

COPY OF CERTIFICATE OF DEATH

Registered No. 177

No. Danvers State Hospital

{(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)}

2 FULL NAME Abraham Pearlstein

(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. 57 Hutchinson St. Winthrop Mass.

(City or town and State)

Length of stay: In place of death.....years.....1 months 12 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from July 13, 1967, to August 25, 1967.
I last saw him alive on August 25, 1967, death is said to have occurred on the date stated above, at 3:20a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardio respiratory failure

(b) Due To Arteriosclerotic heart disease yrs.

(c) Due To Generalized arteriosclerosis yrs.

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus yrs.

Was autopsy performed? No
What test confirmed diagnosis Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 8/29/67

6 Miskan Tefila West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 27, 1967

7 NAME OF FUNERAL DIRECTOR Levine Chapel

ADDRESS Brookline, Mass.

Received and filed SEP 6 1967

(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 Frances Pearlstein (Give maiden name of wife in full) (Prensky)

(or) WIFE of (Husband's name in full)

12 AGE 84 Years 1 Months 23 Days If under 24 hours Hours Minutes

13 Usual Occupation Foreman (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 011-01-7053-A

16 BIRTHPLACE (City) (State or country) Russia

17 NAME OF FATHER Siron Pearlstein

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Sarah (unknown)

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST: Daniel J. Toomey (Registrar of City or Town where death occurred)

DATE FILED September 1, 1967

MARGIN RESERVED FOR BINDING
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-5-61-938000

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

M R-303

nd 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. 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.

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

WINTHROP

(City or Town making this return)

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No. 178

EN ROUTE TO WINTHROP COMMUNITY HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ABRAHAM BROWN
(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)

Summer

(a) Permanent Residence, No. H3 SHORE DRIVE WINTHROP, MASSACHUSETTS
(Usual place of abode) (If nonresident, give city or town and State)

PERMANENT RESIDENCE: 164 BELLINGHAM STREET, CHELSEA, MASS.
Length of stay: In place of death... months... days. In place of residence 40 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST 27 1967
(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? NO

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Leonard Atkins, M.D.

LEONARD ATKINS, M.D.
(Print or Type Name)

(Address) BOSTON, MASS. Date AUG. 27, 1967

7 RABBI ISAAC EICHONIN CEMETERY, EVERETT
Place of Burial or Crementation. (City or Town)

DATE OF BURIAL AUGUST 29 1967

8 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERVICE, INC.
ADDRESS 151 WASHINGTON AVE., CHELSEA

Received and filed John A. Clark AUG 28 1967

A TRUE COPY ATTEST: (Registrar)

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 MOLIE (RAYMOND)
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

13 AGE 73 Years 2 Months 10 Days If under 24 hours
Hours Minutes

14 Usual Occupation: PROPRIETOR
(Kind of work done during most of working life)

15 Industry or Business: TAVERN

16 Social Security No. 023-05-1617

17 BIRTHPLACE (City) RUSSIA
(State or country)

18 NAME OF FATHER JACOB BROWN

19 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

20 MAIDEN NAME OF MOTHER ROSE (C.E.L.)

21 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

22 Informant MRS. MOLIE (RAYMOND) BROWN
(Address) 164 BELLINGHAM ST., CHELSEA

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health Aug. 28, 1967
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL

DATE OF ENTERING M

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND (

SERVICE NUMBER

Type Copy for State House +

for Chelsea - omit

W.N. Shore IR address -

we only Chelsea address

PER MR. Kloss

8-2967

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

Be filed for burial permit
with Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

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
he made of dying,
uch as heart failure,
sthenia, 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).

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

Elizabeth

2 FULL NAME ANNIE SMITH (Mc Naught)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 30 WILLOW AVE., WINTHROP St. MASS.
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 80 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 27 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from July 20, 1967, to August 27, 1967

I last saw him alive on August 26, 1967, death is said to have occurred on the date stated above, at 4:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial infarction

(b) Due To Arteriosclerotic Heart Disease

(c) Due To Generalized Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Adenocarcinoma of Sigmoid Colon 2 mos.

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. Traubstein Jr. M. D.

(Address) 73 Bartholomew St. Wintthrop, Mass. Date Aug 27, 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 30, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed AUG 30 1967

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. 179

(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 married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of William Augustus Smith
(Husband's name in full)12 AGE 80 Years 0 Months 10 Days If under 24 hours
Hours Minutes13 Usual Occupation medical secretary
(Kind of work done during most of working life)

14 Industry or Business: Physicians office

15 Social Security No. 032-03-3932-A

16 BIRTHPLACE (City) Beachmont
(State or country) Massachusetts

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) Maine
(State or country)

21 Informant William A. Smith

(Address) 30 Willow 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)
Dir. of Public Health Aug 30 1967
(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.

FORM R-301

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.

180

Be filed for burial permit
with Board of Health
or its Agent.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)INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

2 FULL NAME William Arnold Abbott

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) WW #1

(a) Permanent Residence. No. 31 Palmyra St.

St.

(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 30, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Dec 1967 to Aug 30 1967
I last saw him live on Aug 30 1967 death is said to
have occurred on the date stated above, at 10:30 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinoma of pancreas

Due To (b) Carcinoma of pancreas ? 3 weeks

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signature) H. J. O'Malley, M. D.

447 Shirley (Print or Type Name)

(Address) Winthrop Mass. Date 8-30 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 2, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Malley

ADDRESS Winthrop, Mass.

Received and filed SEP 1 1967

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
HUSBAND of Lillian M. Gallagher
(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.....Minutes13 Usual Occupation President Munroe Co
(Kind of work done during most of working life)

14 Industry or Business: Plumbing Supplies

15 Social Security No. 012-07-7788

16 BIRTHPLACE (City) South Waterrford
(State or country) Maine

17 NAME OF FATHER William E. Abbott

18 BIRTHPLACE OF FATHER (City) South Paris
(State or country) Maine

19 MAIDEN NAME OF MOTHER Mae Barrett

20 BIRTHPLACE OF MOTHER (City) Maine
(State or country)

21 Informant Lillian M. Abbott

(Address) 31 Palmyra St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip P. Vitagliano (M.D.)
(Signature of Agent of Board of Health or other)Director of Public Health 9/11/67
(Official Designation) (Date of Issue of Permit)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 given
in (a).

PARENTS

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 6-23-17

DATE OF DISCHARGE..... 7-21-19

RANK, RATING Sgt

ORGANIZATION AND OUTFIT..... U.S. Marines

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

Be filed for burial permit
with Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

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
he mode of dying,
uch as heart failure,
sthenia, etc. It means
he disease, or complica-
tions which caused
eath.

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

WINTHROP
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 181

1 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)

2 FULL NAME SCOPPETTUOLO, KENAX LENA
(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. 31 ST. ANDREW RD. St. EAST BOSTON, MASS.
(City or town and State)

Length of stay: In place of death.....years.....months17days. In place of residence60years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug. 30 - 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 19, 1966, to Aug. 30, 1967.
I last saw him alive on Aug. 29, 1967, death is said to have occurred on the date stated above, at 7 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive Pulmonary INFARCTION

(b) Due To thrombopilebitis of leg

(c) Due To Metastatic Carcinoma of Lung

INTERVAL
BETWEEN
ONSET AND
DEATH

3 days

3 days

OTHER SIGNIFICANT CONDITIONS Red leg (Right) 1966 for Carcinoma of Breast

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) Charles M. Tilton, M. D.
(Print or Type Name)

(Address) 15 Cambridge St., Date Aug 30 1967

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 2nd 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed AUG 31 1967

(Signature) John D. Clark (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 60 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Stitcher (Kind of work done during most of working life)

14 Industry or Business: Awnings

15 Social Security No. 012-07-8013

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER Anthony Scoppettuolo

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Carmela Vitagliano

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant Mrs. Madeline Rego-sister

(Address) 31 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:

(Signature of Agent of Board of Health or other)

(Official Designation) Director of Public Health

(Date of Issue of Permit) 8/31/67

SPACED 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 31 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

100M-8-66-943275

(Official Designation) (Date of Issue of Permit)

OCT 4 '67 AM



CLERK

SSA

City Registrar

William J. Bone

A TRUE COPY ATTEST:

FORM R-301A

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

In giving
CAUSE 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).

Note:- Chapter 137,
Acts of 1954, requires
Physicians to print or
type the cause or
causes of death on
death certificates, and
Chapter 48, Acts of
1959, requires Physi-
cians to print or type
name under signature.

100M-6-60-928145

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Suffolk
(County)
Jamaica Plain
(City or Town)

PLACE OF DEATH
1. **Duplex Nursing Home**
No. **Gilbert G. Hewitt**
Gilbert G. Hewitt
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

STANDARD
CERTIFICATE OF DEATH

2. **FULL NAME** **Gilbert G. Hewitt**
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. **19 Moore Street** St. **Winthrop, Mass.**
(Usual place of abode)

Length of stay: In place of death. **1** years **30** months **0** days. In place of residence **30** years **0** months **0** days.
(If nonresident, give city or town and State)

MEDICAL CERTIFICATE OF DEATH

3. **DATE OF DEATH** **7-11-67**
(Month) (Day) (Year)

4. I HEREBY CERTIFY, That I attended deceased from **6-10-67**, 19**67**, to **7-11-67**, 19**67**.
I last saw him alive on **7-10-67**, 19**67**, death is said to have occurred on the date stated above, at **9:30 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) **Acute Dilatation of Heart**

Due To (b) **Cardiovascular Disease** year **18**
Due To (c) **Pulmonary Emphysema**

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) **Elia Calabrese**, M. D.
Elia Calabrese
(PRINT OR TYPE SIGNATURE)
(Address) **2 Hancock St. Boston** Date **7-11-67**, 19**67**

6. **Woodlawn Crematory** **Everett**
Place of Burial or Cremation (City or Town)
July 13 **67**
DATE OF BURIAL

7. **NAME OF FUNERAL DIRECTOR** **Howard S Reynolds**
Winthrop, Mass.
ADDRESS

Received and filed **JUL 13 1967**
William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8. **SEX** **Male** 9. **COLOR** **White** 10. **SINGLE** (write the word) **MARRIED**
WIDOWED **Single**
or **DIVORCED**

10a. If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) **WIFE of** (Husband's name in full)

11. IF STILLBORN, enter that fact here.

n-85 5 27
AGE Years Months Days
If under 24 hours
Hours Minutes

13. Usual Occupation: **Jeweler**
(Kind of work done during most of working life)

14. Industry or Business: **Retail Jewelry**

15. Social Security No. **010-03-4929**

16. **BIRTHPLACE (City)** **Birmingham**
(State or country) **England**

PARENTS

17. **NAME OF FATHER** **Unable to obtain**

18. **BIRTHPLACE OF FATHER (City)** **Unable to obtain**
(State or country)

19. **MAIDEN NAME OF MOTHER** **Unable to obtain**

20. **BIRTHPLACE OF MOTHER (City)** **Unable to obtain**
(State or country)

21. Informant **Janet S Howard**
(Address) **19 Moore 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)
9/13/66 **July 11, 1967**
(Official Designation) (Date of Issue of Permit)

OCT 4 1967

A TRUE COPY ATTEST!

William J. Kane.
City Registrar

OCT 4 '67 AM



OFFICE OF THE CITY CLERK
WILMINGTON, MASS.

FORM R-303

To 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.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,
§§ 43-45.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

1904-9-63-936348

PLACE OF DEATH

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)

184

MEDICAL EXAMINER'S
CERTIFICATE OF DEATHRegistered No. ~~109753~~

No. 974 Saratoga St., East Boston

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

2 FULL NAME PATRICK

FOLEY

(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. 40 Sunnyside 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 DEATH July 12, 1967
(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 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

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 7/12 67

7 WINTHROP WINTHROP
Place of Burial or Creonation (City or Town)

DATE OF BURIAL JULY 14, 1967

8 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS 210 WINTHROP ST. WINTHROP 70

Received and filed JUL 14 1967

A TRUE COPY ATTEST:

OCT 4 1967

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

male

10 COLOR

white

11 SINGLE

MARRIED

WIDOWED

DIVORCED

UNKNOWN

(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

65 Years

Months

Days

If under 24 hours

Hours

Minutes

14 Usual

Occupation:

(Kind of work done during most of working life)

15 Industry

or Business:

BAR AND GRILL

16 Social Security No.

not known

17 BIRTHPLACE (City)

(State or country)

EAST BOSTON

18 NAME OF

FATHER

JAMES PATRICK FOLEY

19 BIRTHPLACE OF

FATHER (City)

(State or country)

EAST BOSTON

20 MAIDEN NAME

OF MOTHER

MARY E O'DONNELL

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

EAST BOSTON

22 Informant

(Address)

JAMES L. FOLEY

40 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:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

OCT 4 '67 AM



TOWN CLERK

MASS.

City Registrar

William J. Kane

A TRUE COPY ATTEST:

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.

PLACE OF DEATH

Essex
(County)Danvers
(City or Town)

No. Danvers State Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Doris Levy (Rubenstein)
(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 Grovers Avenue

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 5 years 5 months 1 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 28, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
March 27, 1962, to August 28, 1967.
I last saw alive on August 28, 1967, death is said to
have occurred on the date stated above, at 8:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary infarct

INTERVAL
BETWEEN
ONSET AND
DEATH
mins.

(b) Due To Arteriosclerotic heart disease yrs.

(c) Due To Generalized arteriosclerosis yrs.

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 8/29/67

6 Staro Konstantino W. Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 29, 1967

7 NAME OF FUNERAL DIRECTOR Levine Chapel, Inc.

ADDRESS Brookline, Mass.

Received and filed SEP 14 1967

(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 Samuel Levy
(Husband's name in full)12 AGE 83 Years 7 Months 25 Days If under 24 hours
Hours Minutes13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 010-03-9749

16 BIRTHPLACE (City) Lithuania
(State or country)

17 NAME OF FATHER Ephraim Rubenstein

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Fannie Klenovich

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY Daniel J. Toomey

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED September 1, 1967

MARGIN RESERVED FOR BINDING
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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

FORM R-301

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 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).

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 (City or Town)
No. **49 HUTCHINSON ST**

2 FULL NAME **ROSE BRAFF**
(If deceased, a mother, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. **49 HUTCHINSON** St. **WINTHROP**
(City or town and State)

Registered No. **186**

(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**

Length of stay: In place of death **45** years.....months.....days. In place of residence **45** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH Sept 1, 1967 (Month) (Day) (Year)	8 SEX FEMALE	9 COLOR WHITE	10 SINGLE (write the word) WIDOWED
4 I HEREBY CERTIFY, That I attended deceased from JAN, 1952 , to Sept 1, 1967 I last saw her alive on Aug. 31, 1967 , death is said to have occurred on the date stated above, at 2:30 P.M.	11 If married, widowed, or divorced HUSBAND of SAMUEL BRAFF (Give maiden name of wife in full) (or) WIFE of SAMUEL BRAFF (Husband's name in full)		
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive ARTERIOSCLEROTIC	12 AGE 77 Years.....Months.....Days If under 24 hours Hours.....Minutes		
Due To HEART DISEASE (b) 15yrs	13 Usual Occupation HOUSEWIFE (Kind of work done during most of working life)		
Due To (c)	14 Industry or Business AT HOME		
OTHER SIGNIFICANT CONDITIONS NONE	15 Social Security No.....		
Was autopsy performed? No	16 BIRTHPLACE (City) RUSSIA (State or country)		
What test confirmed diagnosis? clinical	17 NAME OF FATHER MEYER ROSS		
5 Was disease or injury in any way related to occupation of deceased No If so, specify	18 BIRTHPLACE OF FATHER (City) RUSSIA (State or country)		
(Signature) Charles Lieberman , M. D. CHARLES LIEBERMAN (Print or Type Name)	19 MAIDEN NAME OF MOTHER C. B. L.		
(Address) WINTHROP, MASS Date 9/1/1967	20 BIRTHPLACE OF MOTHER (City) RUSSIA (State or country)		
6 BETH DAVID, WOBURN Place of Burial or Cremation (City or Town)	21 Informant MRS MARION LAUB (Address) 49 HUTCHINSON ST, WINTHROP		
DATE OF BURIAL SEPT. 3, 1967	I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Philip G. Vitagliano (Signature of Agent of Board of Health or other) Dir. of Public Health (Official Designation) 9/2/67 (Date of Issue of Permit)		
7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SRV. INC. ADDRESS 151 WASHINGTON AVE., CHELSEA	Received and filed SEP 6 1967 John A. Clark (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. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, 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)

FORM R-301

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No. 187

No. Viking Nursing Home

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marion A. Merrill

(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. 26 Faun Bar Avenue
(Usual place of abode)

St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death, 1 years, 1 months, 1 days. In place of residence, 50 years, 1 months, 1 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 1, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 30, 1967, to Sept 1, 1967

I last saw her alive on August 30, 1967, death is said to have occurred on the date stated above, at 6:15 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia terminal

Due To (b) Carcinoma of Breast

Due To (c)

OTHER SIGNIFICANT CONDITIONS
Arteriosclerosis Gen.

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) [Signature], M. D.

(Print or Type Name)

(Address) [Address] Date Sept 1, 1967

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 5, 1967

7 NAME OF FUNERAL DIRECTOR Alfred P. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed SEP 5 1967

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 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 93 Years 9 Months 16 Days If under 24 hours Hours Minutes

13 Usual Occupation Christian Science Reader (Kind of work done during most of working life)

14 Industry or Business self employed

15 Social Security No. 033-26-5689-A

16 BIRTHPLACE (City) Hinckley (State or country) Illinois

17 NAME OF FATHER Francis E. Merrill

18 BIRTHPLACE OF FATHER (City) Washington (State or country) D.C.

19 MAIDEN NAME OF MOTHER (unknown) Costler

20 BIRTHPLACE OF MOTHER (City) U.S.A. (State or country)

21 Informant Harry A. Saunders, Adm.

(Address) 259 Beacon St. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[Signature] (Signature of Agent of Board of Health or other)

[Signature] (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.

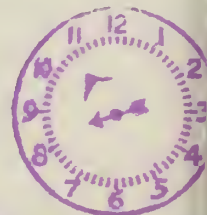
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

SEP 5 '67 AM



OFFICE OF THE TOWN
 WINTHROP, MASS.

VM VM

FORM R-301

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. 188

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

HARRY BROWN

(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.

26 FORREST STREET

St. WINTHROP, MASS

(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 SEPTEMBER 5 1967

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

you, 1967 to Sept 5, 1967

I last saw him live on Sept 5, 1967, death is said to

have occurred on the date stated above, at 12:07 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolism

(b) Due To

(c) arteriosclerosis

(d) Due To

(e) diabetes, arterial

OTHER

SIGNIFICANT

CONDITIONS

Diabetes, arterial
hypertension - Angina

Was autopsy performed? no

What test confirmed diagnosis? X-Ray

5 Was disease or injury in any way related to occupation of deceased?

If so, specify no

(Signature) H. B. (300 St. Field), M. D.

447 St. W. (Print or Type Name)

(Address) W. (City or Town) Date Sept 5, 1967

6 IND. PRIDE of BOSTON West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPTEMBER 7, 1967

7 NAME OF FUNERAL DIRECTOR LEVINE CHAPEL

ADDRESS 470 HARVARD ST. BROOKLINE

Received and filed SEP 5 1967

A TRUE COPY ATTEST:

(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 BESSIE KAPLAN

(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

SALESMAN

(Kind of work done during most of working life)

14 Industry

or Business:

MACHINERY

15 Social Security No.

079-40-1876

16 BIRTHPLACE (City)

(State or country)

BOSTON MASS.

17 NAME OF

FATHER

HYMAN BROWN

18 BIRTHPLACE OF

FATHER (City)

(State or country)

RUSSIA

19 MAIDEN NAME

OF MOTHER

SARAH (UNKNOWN)

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

RUSSIA

21 Informant

MRS. BESSIE BROWN

(Address) 26 FORREST ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitashko

(Signature of Agent of Board of Health or other)

Director of Public Health 9/5/67

(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.

SEP 5 '67



OFFICE OF THE TOWN
WINTHROP, MASS.

FORM R-301

Agent for burial permit
Agent.

INSTRUCTIONS
FOR
FILLING OUT
THIS CERTIFICATE

1. TYPE
2. OR CAUSES
OF DEATH

3. not enter
more than one
cause for each
(a), (b) and (c)

4. does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
cation, which caused

5. conditions, if any,
which gave rise to
the cause (a),
including the under-
lying cause last.

6. conditions contrib-
uting to death but not
leading 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. 189

No. 170 CLIFF AVE
Cliff House Nursing Home

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. ANNA TATELMAN
(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. 131 Spruce St
(Usual place of abode) Chelsea
(City or town and State)

Length of stay: In place of death, years, months, 10 days. In place of residence, 30 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT. 5, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
AUG 30, 1967 to SEPT 5, 1967
I last saw her alive on SEPT 4, 1967 death is said to
have occurred on the date stated above, at 7:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION 1967

Due To
(b) ARTERIO SCLEROTIC HEART DS.

Due To
(c)

OTHER SIGNIFICANT CONDITIONS CARCINOMATOSIS
PRIMARY LEFT BREAST 1952

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.
(Print or Type Name)

(Address) 126 PRINCETON ST. BOSTON 9-5, 1967

6 AGUDOS ACHIM MELROSE
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 6, 1967

7 NAME OF FUNERAL DIRECTOR TORF Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed SEP 6 1967

John D. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Fem 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 ISAAC TATELMAN
(Husband's name in full)

12 AGE 70 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business AT Home

15 Social Security No. 014-20-3193

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER SAMUEL KRICKMAR

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER Bessie C. B. L.

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

21 Informant Bessie Tatelman
(Address) 131 Spruce St Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vitagliano (S)
(Signature of Agent of Board of Health or other)

Div. of Public Health 9/6/67
(Official Designation) (Date of Issue of Permit)

Chelsea notified 10-9-67

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

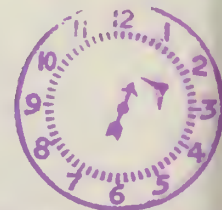
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 6 '67 AM



OFFICE OF THE TOWN CL
WINTHROP, MASS.

FORM R-301

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
Winthrop
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 190

No. Viking Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)2 FULL NAME Ralph Young
(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. 131 Union St. Lynn

(City or town and State)

Length of stay: In place of death, years, months, 21 days. In place of residence, 62 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 5 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Aug. 23, 1967, to Sept. 5, 1967I last saw him alive on Aug. 31, 1967, death is said to
have occurred on the date stated above, at 12:05 noon

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

(b) Arteriosclerosis gen

(c) Robinson's 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 E. GREGG, M. D.

(Address) 19-16-85-89
Date 9/5/676 Pine Grove Lynn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 7 1967

7 NAME OF FUNERAL DIRECTOR W. C. Parker

ADDRESS Lynn Mass

Received and filed SEP 6 1967

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 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 (Husband's name in full)

12 AGE 80 Years, 1 Months, 18 Days If under 24 hours
Hours Minutes13 Usual Occupation Ticket Agent
(Kind of work done during most of working life)

14 Industry or Business: B. & M. R.R.

15 Social Security No. 010-15-8589

16 BIRTHPLACE (City) Ipswich
(State or country) Mass.

17 NAME OF FATHER Ambrose Young

18 BIRTHPLACE OF FATHER (City) Digby
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Mary M. Phail

20 BIRTHPLACE OF MOTHER (City) River Dennis
(State or country) Cape Breton Canada

21 Informant Alice Walfield

(Address) 67 Jackson St. Lynn

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip H. Vitagliano (Mek)
(Signature of Agent of Board of Health or other)Director of Public Health 9/6/67
(Official Designation) (Date of Issue of Permit)

(Registrar)

(Date of Issue of Permit)

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).

8NN-10-9-67

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 6 1917



OFFICE OF THE T
WINTHROP.

The Commonwealth of Massachusetts

FORM R-301

Suffolk

(County)

Winthrop

(City or Town)

No. 4 Highland Ave.


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 191

 (If death occurred in a hospital or institution,
 St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

 2 FULL NAME Alfred Howard Bagness
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

 (Was deceased a
 U. S. War Veteran,
 if so specify WAR)

4 Highland Ave

(a) Residence, No. (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 SEPT 6 1967
 (Month) (Day) (Year)
 4 I HEREBY CERTIFY That I attended deceased from
 Nov 1 1955 to SEPT 6 1967
 I last saw him alive on SEPT 5 1967, death is said to
 have occurred on the date stated above, at 9:45 p.m.

 INTERVAL
 BETWEEN
 ONSET AND
 DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART DISEASE 9 MOS

(b) Due To Pulmonary bronchitis & EMPHYSEMA 12YRS

(c) Due To

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 9 MOS

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Laboratory

 5 Was disease or injury in any way related to occupation of deceased?
 If so, specify

(Signature) M. Traunstein M. D.

(Print or Type Name) M. TRAUNSTEIN

(Address) 73 Bartlett Rd, Winthrop, Mass. Sept 6, 1967

 6 Winthrop Winthrop
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 9 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed SEP 8 1967

(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 Ruth (Day) Bagness
 (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 60 Years 10 Months 24 Days If under 24 hours Hours Minutes

 13 Usual Occupation: Superintendent
 (Kind of work done during most of working life)

14 Industry or Business Manufacture Brass Products

15 Social Security No. 031-01-3623

16 BIRTHPLACE (City) Winthrop Mass. (State or country)

17 NAME OF FATHER Alfred T Bagness

18 BIRTHPLACE OF FATHER (City) Boston Mass. (State or country)

19 MAIDEN NAME OF MOTHER Louisa Baxter

20 BIRTHPLACE OF MOTHER (City) Boston Mass. (State or country)

 21 Informant Ruth Bagness
 (Address) 4 Highland Ave. Winthrop

 I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vito (1/3)

(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.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DELIVERY

1

SUFFOLK

(County)

WINTHROP

(City or Town)

No.

WINTHROP COMMUNITY HOSPITAL



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 192

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS O'CONNELL FEMALE
(if given)3 DATE OF DELIVERY 9/7/67
(Month) (Day) (Year)4 SEX
Male.....Female..XUndetermined

5 COLOR (if determined) WH

6 THIS BIRTH (Check one)
Single. Twin Triplet7 IF MULTIPLE BIRTH, BORN:
1st.....2nd.....3rd.....8 FATHER
FULL NAME KEVIN O'CONNELL9 RESIDENCE, NO. 27 CHELSEA STREET
CITY OR TOWN EAST BOSTON STATE MASS

10 COLOR OR RACE WHITE 11 AGE AT TIME OF THIS DELIVERY 20 (Years)

12 PLACE OF BIRTH BOSTON, MASS
(City or Town) (State or country)

13 OCCUPATION SHIPPER

14 MOTHER
MAIDEN NAME HELEN HALL
PRESENT NAME HELEN O'CONNELL15 RESIDENCE, NO. 27 CHELSEA STREET
CITY OR TOWN EAST BOSTON STATE MASS

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 22 (Years)

18 PLACE OF BIRTH WINTHROP, MASS
(City or Town) (State or country)

19 INFORMANT HELEN O'CONNELL

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) 1

(a) How many children are now living? 1

(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 36 completed weeks

22 WEIGHT OF FETUS 2 Lb. 10 Oz.
(or Grams)23 WHEN DID FETUS DIE? *and*
Before Labor ☒ During Labor ☐ Unknown ☐24 AUTOPSY Yes No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ANENCEPHALIC and
Due To (b) HYDRAMNIOS CAUSE
Due To (c) UNDETERMINED

OTHER SIGNIFICANT CONDITIONS NONE

26 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 9-8-67 196727 NAME OF FUNERAL DIRECTOR Marjorie W. Kirby
ADDRESS 210 Winthrop St.

Received and filed September 7, 1967

A TRUE COPY ATTEST:

(Registrar)

I HEREBY CERTIFY that this delivery occurred on the date stated above at 9:20 A.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 22 PLEASANT ST WINTHROP MASS Date 9/7/67

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 9/7/67
(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
as stillbirth
rematurity.)al and/or mal-
formation con-
ditions, y, which gave
rise to above
(a), stating
underlying
cause last.ditions of fetus
other which
have contrib-
uted to fetal
death, but, in so
far as is known,
not related
to cause given
(a).

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

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

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 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).

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. 193

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 34 Hawthorn Ave.

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edith Fishman
(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. 380 Shirley St. Winthrop
(City or town and State)

Length of stay: In place of death... years... months... 14 days. In place of residence... 15 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 13 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
SEPT. 25, 1966, to SEPT. 13, 1967.

I last saw him alive on SEPT. 4, 1967 death is said to
have occurred on the date stated above, at 9 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL ARTERIAL THROMBOSIS 3 yrs

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS PARALYSIS OF LOWER
EXTREMITIES 2 yrs

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL COURSE

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myer Fishman, M. D.

Myer Fishman, M.D.

(Print or Type Name)

(Address) 483 Beacon St. Date: 9/13/67

Boston, Mass.

Beth Israel of Cambridge, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 14 1967

7 NAME OF FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed SEP 14 1967

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 (Give maiden name of wife in full)

(or) WIFE of Dr. Hyman Fishman
(Husband's name in full)

12 AGE 68 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.

16 BIRTHPLACE (City)... cnbl
(State or country) Rumania

17 NAME OF FATHER Samuel Baratt

18 BIRTHPLACE OF FATHER (City)... cnbl
(State or country) Rumania

19 MAIDEN NAME OF MOTHER Fay (unknown)

20 BIRTHPLACE OF MOTHER (City)... cnbl
(State or country) Rumania

21 Informant Leonard Rosenberg
(Address) 34 Hawthorne Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vaghians (Signature of Agent of Board of Health or other)

Dir. of Public Health Sept 14 1967
(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.

INSTRUCTIONS
FOR
CERTIFICATEI giving
OF DEATH

not enter
than one
for each
(b) and (c)

es not mean
of dying,
as heart failure,
etc. It means
ee, or compli-
which caused

ins, if any,
have rise to
e cause (a),
n, the under-
ause last.

ommons contrib-
to death but not
the terminal
dition given

ot - Chapter 137,
a 1954 requires
sians to print or
e he cause or
e of death on
thertificates, and
pt 48, Acts of
quires Physi-
so print or type
nder signature.

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 191

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME MARGUERITE M. HICKEY (Doherty)

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, No
if so specify WAR)}

(a) Residence, No. 207 Bellingham Avenue
(Usual place of abode)

St. Revere
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 14, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 15, 1967, to Sept. 14, 1967
I last saw her alive on Sept. 14, 1967, death is said to
have occurred on the date stated above, at 10:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Ca. of Pancreas

INTERVAL
BETWEEN
ONSET AND
DEATH

3 months, 4

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO
What test confirmed diagnosis? Exploratory Laparotomy
June 21, 1967

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) John F. Collins M.D.
John F. Collins
(Print or Type Name)

(Address) 27 Bennington St. Date Sept. 15, 1967

Revere, Mass.
Woodlawn

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL 9/18/67

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS Revere, Mass.

Received and filed SEP 15 1967

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☒ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of

(or) WIFE of George H. Hickey
(Husband's name in full)

12 DATE OF BIRTH 12/1/02

AGE 54 Years 9 Months 13 Days If under 24 hours
Hours Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 021-10-8237

17 BIRTHPLACE (City) Boston
(State or country) Mass.

18 NAME OF FATHER Michael Doherty

19 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

20 MAIDEN NAME OF MOTHER Ellen Doherty (ok)

21 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

22 Informant George M. Hickey
(Address) 207 Bellingham Av., Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 195

No. Viking Nursing Home

{(If death occurred in a hospital or institution,
St. {give its NAME instead of street and number)}

2 FULL NAME

Josephine Nasta (Cenci)

(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.

965 Saratoga St. East Boston

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 4 years 4 months days. In place of residence 5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF

DEATH

Sept 14, 1967
(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 P. m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to
natural causes. Patient(b) Due To known to be ill with
metastatic mucinous carcinoma(c) Due To WINTHROP BOARD OF HEALTH
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? No
If so, specify

(Signed) Charles Liberman M. D.

(Address) WINTHROP, MASS Date 9/14/1967

6 Place of Burial or Cremation Holy Cross Malden
(City or Town)

DATE OF BURIAL Sept. 18 1967

7 NAME OF FUNERAL DIRECTOR Vincent J. Mazzarella

ADDRESS 971 Saratoga St. E.B.

Received and filed SEP 15 1967 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED Married
WIDOWED
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Alphonso Nasta

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 57

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)

(State or country)

New York

17 NAME OF FATHER

Vincent Cenci

18 BIRTHPLACE OF

FATHER (City)

Italy

(State or country)

19 MAIDEN NAME

OF MOTHER

Philomena DiBenedetto

20 BIRTHPLACE OF

MOTHER (City)

Italy

(State or country)

21

Informant Alphonso Nasta

(Address) 965 Saratoga St. E.B.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (s)

(Signature of Agent of Board of Health or other)

Div. of Public Health 9/15/67

(Date of Issue of Permit)

50M-1-58-921876

Refer to Board of Health by Medical Examiner

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

FORM R-301

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 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).

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. 196

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Cliff House Nursing Home St. Winthrop (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME CHRISTINE MCISAAC
(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. 75 WOODSIDE AVE St. WINTHROP
(City or town and State)

Length of stay: In place of death 24 hrs. years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 15, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
DECEMBER 3, 1966 to SEPT 15, 1967

I last saw her alive on SEPT 14, 1967 death is said to
have occurred on the date stated above, at

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION(b) ARTERIO SCLEROSIS -(c) GENERALIZED

OTHER SIGNIFICANT CONDITIONS CHRONIC NEPHRITIS 1 YR

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

(Signature) A. N. Caplan M. D.
A. N. CAPLAN MD
(Print of Type Name)

(Address) 186 PRINCE ST. Date 9/15/67
A. BOSTON

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 18, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed SEP 15 1967

J. R. O'Leary (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 56 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: HOME

15 Social Security No. 025-26-9727

16 BIRTHPLACE (City).....
(State or country) NOVA SCOTIA

17 NAME OF FATHER HUGH MCISAAC

18 BIRTHPLACE OF FATHER (City).....
(State or country) NOVA SCOTIA

19 MAIDEN NAME OF MOTHER FLORENCE (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City).....
(State or country) NOVA SCOTIA

21 Informant MRS FLORENCE HANNA FORD

(Address) 75 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:

Philip G. Botaylione (M.D.)
(Signature of Agent of Board of Health or other)

Director of Public Health 9/15/67
(Official Designation) (Date of Issue of Permit)

Voter - 170 C1, 64 A1E

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.

34

FORM R-301

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. 197

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 Agnes MacLennan (McKie)
(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. 104 Tafts Ave.

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 SEPT 20 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from June 6, 1967, to SEPT 20, 1967.
I last saw her alive on SEPT 20, 1967, death is said to have occurred on the date stated above, at 3:48 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCCLUSION

Due To (b) ARTERIO-SCLEROTIC HEART DISEASE

(c) NIDIOARTERIO SCLEROSIS

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M.D.

(Print or Type Name) MYRON N. KING, M.D.

(Address) 122 OCEAN ST. Date 9/20/67

6 Newton Cemetery Newton
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 22 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed SEP 21 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 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 Duncan A MacLennan
(Husband's name in full)12 AGE 84 Years 0 Months 18 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. 032-14-4005

16 BIRTHPLACE (City) Scotland
(State or country)

17 NAME OF FATHER Ferdinand McKie

18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)

19 MAIDEN NAME OF MOTHER Isabella Kelso

20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)

21 Informant Alice M MacLennan

(Address) 14 Oakland Ave. Auburndale,

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip S. V. [Signature]
(Signature of Agent of Board of Health or other)Dir of Public Health 9/21/67
(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
more than one
cause for each
of (a), (b) and (c)This does not mean
mode of dying,
such as heart failure,
hemiplegia, etc. It means
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).

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
OF DEATH

not enter
more than one
for each
(b) and (c)

does not mean
cause of dying,
heart failure,
etc. It means
cause, or compli-
cation which caused

causes, if any,
which have rise to
the cause (a),
or the under-
lying cause last.

conditions contrib-
ute to death but not
the terminal
condition given

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)

STANDARD CERTIFICATE OF DEATH

Registered No. 198

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 15 Thornton Street

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Winnifred Wallcott Powell
(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 Thornton Street
(Usual place of abode)

st. Winthrop, Mass.
(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 September 20 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19 to 19

I last saw h. alive on 19 death is said to
have occurred on the date stated above, at 10:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
(b) to 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 9/29/67

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 27, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed SEP 27 1967

John A. Cline

(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 A. Powell
(Husband's name in full)

12 AGE 76 years 4 Months 15 Days If under 24 hours
Hours Minutes

13 Usual Occupation retired bookkeeper
(Kind of work done during most of working life)

14 Industry or Business Winthrop Savings Bank

15 Social Security No. 025-26-4477

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts

17 NAME OF FATHER Wilfred Wallcott

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Rebecca Wilder

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant Carl Lindsey
(Address) 119 Chesnut St. Andover

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vitashenski
(Signature of Agent of Board of Health or other)
Sur of Public Health 9/27/67
(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.

SEP 2 / '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

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. 199

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 Grace Gavin
(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.....months27days. In place of residence5years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 21, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Dec 1965 to Sept. 21, 1967
I last saw her alive on Sept. 21, 1967, 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 Breast

(b) With generalized

(c) metastasis.

INTERVAL
BETWEEN
ONSET AND
DEATH

6yrs.

OTHER
SIGNIFICANT
CONDITIONS

None.

Was autopsy performed? No
What test confirmed diagnosis? Clinical/Surgical5 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 9/21/676 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT 25 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP, MASS.

Received and filed SEPT 25 1967

A TRUE COPY ATTEST:

(Registrar)

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 MICHAEL P GAVIN
(Husband's name in full)12 AGE 54 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation TELLER
(Kind of work done during most of working life)

14 Industry or Business: BANNYS

15 Social Security No.

16 BIRTHPLACE (City) WORCESTER
(State or country) MASS

17 NAME OF FATHER ALEXANDER GIBSON

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS

19 MAIDEN NAME OF MOTHER ANNA DROLIN

20 BIRTHPLACE OF MOTHER (City) NORTH GRAFTON
(State or country) MASS.

21 Informant PATRICIA GAVIN

(Address) 10 SURFSIDE AVE WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Utoghaman Jr.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 9/25/67
(Official Designation) (Date of Issue of Permit)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 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).

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

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No.

Bayview Nursing Home

STANDARD
CERTIFICATE OF DEATH

Registered No. 200

{(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 Alter Gudowsky
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 7 Nazing Court St. Roxbury
(City or town and State)

Length of stay: In place of death 29 days. In place of residence 12 years.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 27, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Aug. 30, 1967, to 9/27/1967I last saw him alive on 9/26/1967, death is said to
have occurred on the date stated above, at 12:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer Lung, right, bronchio 5 months

(b) genic,

(c)

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? Clinical 1

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 9/27/1967

6 Sharon Memorial Park, Sharon
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 29, 1967

7 NAME OF FUNERAL DIRECTOR Benjamin Binnbach

ADDRESS 1505 Blue Hill Ave. Mattapan

Received and filed SEP 27 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR white 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, divorced,
HUSBAND of Fannie Forman
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 86 Years 11 Months 15 Days If under 24 hours
Hours Minutes13 Usual Occupation Clothing Manufacturer
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 033-26-4067A

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER ISAAC GUDOWSKY

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 Mrs John M. Adamson

(Address) 91 Riverside Circle, Marshfield

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health 9/27/67
(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
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).

Boston - 10-9-67

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.

SEP 27 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

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)

Registered No. 201

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, no
if so specify WAR)INSTRUCTIONS
FOR
MEDICAL CERTIFICATE2 FULL NAME LEO PELLETIER
(If deceased is married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 33 ATLANTIC STREET St. WINTHROP, MASS
(City or town and State)

Length of stay: In place of death. years months 4 days. In place of residence. 5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 29, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
OCT, 1965, to SEPT 29, 1967I last saw him alive on 9/28, 1967, death is said to
have occurred on the date stated above, at 7:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCCLUSION

Due To (b) ARTERIO-SCLEROTIC HEART DIS

Due To (c) MYOCARDIAL ISCHEMIA
- SUPRACARDIAC NECROSIS

OTHER SIGNIFICANT CONDITIONS CHRONIC BRONCHITIS

INTERVAL
BETWEEN
ONSET AND
DEATH
1 HR.

3 YRS

3 YRS

2 WKS

3 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL & ECG

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Myron D. King, M. D.

MYRON D. KING M.D.

(Print or Type Name)

(Address) 222 Pleasant St. WINTHROP, MASS Date SEPT 29, 1967

6 New Calvary Cemetery Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 2, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS WINTHROP, MASS

Received and filed OCT 2 1967 19.

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED WIDOWER
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Mary M. O'Connell
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Bookbinder
(Kind of work done during most of working life)

14 Industry or Business Printing

15 Social Security No. 010-03-8146

16 BIRTHPLACE (City) Canada
(State or country)

17 NAME OF FATHER Ovide Pelletier

18 BIRTHPLACE OF FATHER (City) Canada
(State or country)

19 MAIDEN NAME OF MOTHER Rose Gueret

20 BIRTHPLACE OF MOTHER (City) Canada
(State or country)

21 Informant Leo W. Pelletier Jr.

(Address) 3 Francis Road Lexington, MA

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip S. Vitagliano Jr.
(Signature of Agent of Board of Health or other)Dir. of Public Health 10/2/67
(Official Designation) (Date of Issue of Permit)to be filed for burial permit
with Board of Health
or its Agent.PRINT 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).

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.

FORM R-301

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
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
disease condition given
(a).

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

2 FULL NAME **Hallahan**
James Hallahan

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. **504 Bennington St Boston 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 29 1967**

(Month) (Day) (Year)

6/20/67 DECEASED **BY CERTIFY** **July 29 1967** Deceased from

we last saw him alive on **July 29 1967** death is said to

have occurred on the date stated above, at **12/15 AM**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Bronchopneumonia**

Due To (b) **Fracture of left hip**

Due To (c) **Osteopourosis**

OTHER SIGNIFICANT CONDITIONS **Coronary heart disease**

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 L. Clay**, M.D.

Charles L. Clay, M.D.

(Print or Type Name)

July 29 1967

(Address) **Ass't. Dir., Mass. Gen'l. Hosp.** Date.....19.....

6 **Winthrop** **Winthrop**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **August 1, 1967**

7 NAME OF FUNERAL DIRECTOR **Frederick J. Magrath**

ADDRESS **East Boston**

Received and filed

A TRUE COPY ATTEST:

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

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, W.W.1
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)
married

11 If married, widowed, or divorced
HUSBAND of **Margaret A. Treanor**
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE **86** years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation **Stationery Engineer**
(Kind of work done during most of working life)

14 Industry or Business: **Retired**

15 Social Security No. **021-12-1735**

16 BIRTHPLACE (City) **New York**
(State or country)

17 NAME OF FATHER **William Hallahan**

18 BIRTHPLACE OF FATHER (City) **New York**
(State or country)

19 MAIDEN NAME OF MOTHER **CNEL Applegate**

20 BIRTHPLACE OF MOTHER (City) **New York**
(State or country)

21 Informant **Margaret Hallahan**
(Address) **504 Bennington St. E. Boston**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

(Registrar)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

OCT 27 '67 AM



OFFICE OF THE CITY CLERK
WINSTON-SALEM, N.C.

FORM R-301

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
he 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
cause condition given
(a).

PLACE OF DEATH
Suffolk
(County)
Jamaica Plain
(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)

203

STANDARD
CERTIFICATE OF DEATH

Registered No. ~~12591~~

No. General Shattuck Hosp. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Ruth Beaton (Wife) (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. 2 Highland Ave., Winthrop
(City or town and State)

Length of stay: In place of death 10 years 10 months 10 days. In place of residence 4 years 2 months 10 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 5 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 7/6 1967, to 8/5 1967

I last saw him alive on 8/5 1967, death is said to have occurred on the date stated above, at 6:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia
Due To Multiple myeloma

(b) _____
(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 _____

(Signature) H. Fromm, M. D.

(Address) General Shattuck Hosp. (Print or Type Name)

(Address) General Shattuck Hosp. Date 8/5 1967

6 Puritan Lawn Peabody
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 9. 1967

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike

ADDRESS 305 Beach St. Revere

Received and filed AUG 10 1967

William J. Hanes (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 John Beaton (Husband's name in full)

12 AGE 71 Years 9 Months 4 Days If under 24 hours
Hours _____ Minutes _____

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. _____

16 BIRTHPLACE (City) Bay City
(State or country) Michigan

17 NAME OF FATHER Horace G. Hall

18 BIRTHPLACE OF FATHER (City) Bay City
(State or country) Michigan

19 MAIDEN NAME OF MOTHER Nettie Greenfield

20 BIRTHPLACE OF MOTHER (City) Bay City
(State or country) Michigan

21 Informant John Beaton

(Address) 2 Highland 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. S. Saca 8/12/67
(Signature of Agent of Board of Health or other)

Aug 8 1967
(Official Designation) (Date of Issue of Permit)

OCT 27 1967

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

OCT 27 '87 AM



OFFICE OF TOWN CLERK
WINTHROP, MASS

40

FORM R-301

OUT - OF - TOWN

SUFFOLK
(County)ROXBURY
(City or Town)KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSBoston
(City or Town making this return)

204

STANDARD
CERTIFICATE OF DEATHRegistered No. 1 PLACE OF DEATH ROXBURY No. JEWSH MEMORIAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME ANNA WALLACE KUSHNER (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. 43 Ocean Avenue St. WINTHROP, MASS. (City or town and State)Length of stay: In place of death 48 years 18 months 18 days. In place of residence 18 years 18 months 18 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 12 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from 3 July, 19 67, to 12 August, 19 67.
I last saw him alive on 12 August, 19 67, death is said to have occurred on the date stated above, at 9:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Grade III Astrocytoma of Right Cerebral Hemisphere

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NO
What test confirmed diagnosis? Surgery5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify(Signature) Alberta Kathleen Broughm D., M. D.
ALBERTA KATHLEEN BROUGH M.D.
(Print or Type Name)
(Address) 59 TOWNSEND STREET Date 12 August 19676 Kamingker, West Roxbury
Place of Burial or Cremation (City or Town)DATE OF BURIAL August 13, 19 677 NAME OF FUNERAL DIRECTOR Arnold GolovADDRESS 1668 Beacon St., BrooklineReceived and filed AUG 15 1967 19 67William 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
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Joseph Kushner
(Give maiden name of wife in full)(or) WIFE of Joseph Kushner
(Husband's name in full)12 AGE 63 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 Home15 Social Security No. None16 BIRTHPLACE (City) Gloucester, Mass.
(State or country)17 NAME OF FATHER Abraham Wallace18 BIRTHPLACE OF FATHER (City) Unknown
(State or country)19 MAIDEN NAME OF MOTHER Eva (Unknown)20 BIRTHPLACE OF MOTHER (City) Unknown
(State or country)21 Informant Joseph Kushner
(Address) 43 Ocean Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with the BUREAU before the burial or transit permit was issued:

Robert Spindler
(Signature of Agent of Board of Health or other)
E12426 (Official Designation) 8/12/67 (Date of Issue of Permit)PRINT 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).

OCT 27 1967

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

OCT 27 '67



OFFICE OF THE TOWN CLERK
WINSTON-SALEM, N.C.

137

FORM R-301

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 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).

OUT - OF - TOWN The Commonwealth of Massachusetts

Suffolk

(County)

Brighton

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Brighton

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 1203

No. St. John of God Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Arthur Allison Rolfe

(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. 21 Harbor View Avenue
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 1 years 3 months 17 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 12, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I attended deceased from
4/25, 1966, to 8/12/67
I last saw him alive on 8/12/67, death is said to
have occurred on the date stated above, at 8:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Retroperitoneal Carcinoma

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

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) John A. Dolan, M. D.

John A. Dolan

(Address) 296 Allston St. Brookline, Mass. Date 8-12-1967

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 16 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
East Boston

ADDRESS

Received and filed AUG 17 1967

William J. Rowe
(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 Josephine Bright
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 59 Years 3 Months 12 Days If under 24 hours
Hours Minutes

13 Usual Occupation Machinist
(Kind of work done during most of working life)

14 Industry or Business retired
030-20-0395

15 Social Security No. 030-20-0395
16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Fenwick Rolfe

18 BIRTHPLACE OF FATHER (City) Nova Scotia, Canada
(State or country)

19 MAIDEN NAME OF MOTHER Mary Duffy

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Massachusetts

21 Informant Josephine Rolfe
21 Harbor View 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:

7-P. Maca C-13495
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) Aug 15 1967

A TRUE & FAITHFUL

William J. Kane.
City Registrar

OCT 27 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

14

FORM R-301

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 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).

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Boston 206
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 12549

1 PLACE OF DEATH Suffolk (County)
Boston (City or Town)
Boston Hospital For Women (If death occurred in a hospital or institution,
LYING-IN DIVISION St. (give its NAME instead of street and number)
2 FULL NAME BABY BOY RANDAZZO (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. 59 CREST AVE St. WINTHROP
(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 August 14 1967
(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 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PETECHIAL LUNG HEMORRHAGES(b) Due To MARKED PREMATURETY (650 gm)

(c) Due To

OTHER SIGNIFICANT CONDITIONS CONGENITAL OBLITERATION, (L)
URETER

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) ROSEMARY LEAKE Rosemary Leake M. D.
ROSEMARY LEAKE
(Print or Type Name)

(Address) 100 SUMMER ST. Date 8/16/1967
Boston

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 17 1967

7 NAME OF FUNERAL DIRECTOR F. J. Magrath

ADDRESS East Boston

Received and filed AUG 15 1967 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

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
7 Hours 0 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 ROBERT J. RANDAZZO

18 BIRTHPLACE OF FATHER (City) EVERETT, MASS.
(State or country)

19 MAIDEN NAME OF MOTHER ROSE P. LYNN

20 BIRTHPLACE OF MOTHER (City) Boston, Mass.
(State or country)

21 Informant Boston Hospital For Women

(Address) 201 Longwood Ave, Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Eugene L. Bonner E 12549

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) August 16 1967

OCT 27 1967

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

OCT 27 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

The Commonwealth of Massachusetts

SUFFOLK

(County)

BOSTON

(City or Town)

Massachusetts General Hospital BAKER MEMORIAL

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Boston

(City or Town making this return)

207

STANDARD

CERTIFICATE OF DEATH

Registered No.

CHARLES

2 FULL NAME

C. Edward Magoon

(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. 233A Woodside Ave - Winthrop, Mass

(City or town and State)

Length of stay: In place of death 16 hrs. In place of residence 24 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 19, 1967
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from
August 18, 1967, to August 19, 1967I last saw him alive on August 19, 1967, death is said to
have occurred on the date stated above, at 2:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Cerebral Edema

(a) Due To Cerebral Hemorrhage

(b) Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? Yes
What test confirmed diagnosis? Autopsy5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) [Signature], M. D.

(Address) Charles E. Magoon, M.D.
Ass't. Dir., Mass. Gen'l. Hosp. Date: 8-19-19676 Glenwood Cemetery, Littleton, N.H.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 22, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS Winthrop

Received and filed AUG 1967

William J. Hanc

A TRUE COPY ATTEST:

(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 Gertrude T. Magoon (Richardson)
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years 1 Months 6 Days If under 24 hours
Hours Minutes13 Usual Occupation V.P. H.W. Peabody Associates
(Kind of work done during most of working life)

14 Industry or Business Importers

15 Social Security No. 001-12-7886

16 BIRTHPLACE (City) Manchester
(State or country) New Hampshire

17 NAME OF FATHER Charles Edward Magoon

18 BIRTHPLACE OF FATHER (City) Derby Line
(State or country) Canada

19 MAIDEN NAME OF MOTHER Georgia Ida Southard

20 BIRTHPLACE OF MOTHER (City) Manchester
(State or country) New Hampshire21 Informant Wife Gertrude
(Address) 233A Woodside Ave WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Magoon, Ronald E. 12-6-73
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

PLACE OF DEATH

1

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).

OCT 27 1967

Funeral Director:
Please use only
BLACK ink.

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

OCT 27 '67 AM



OFFICE OF THE CITY CLERK

WINTHROP - MASS.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Malden 208
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH

Middlesex
(County)

Malden
(City or Town)

No. Malden Nursing Home

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Joseph Goodman

(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 Moore St.

St. Winthrop

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 1, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Aug. 24, 1967, to Sept. 30, 1967

I last saw him alive on Sept. 30, 1967, death is said to
have occurred on the date stated above, at 11:30 A.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardio Vascular Sclerosis s mos.

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 no
If so, specify

(Signature) Abraham Bloom, M. D.

217 Cross St.
(Address) Malden, Mass. Date 10-1 67

Kopaigorod Cemetery West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 2, 1967

7 NAME OF FUNERAL DIRECTOR Murray Goldman

ADDRESS 174 Ferry St. Malden, Mass.

Received and filed OCT 4 1967

John A. Clark
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M. 9 COLOR W. 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED Wid.
UNKNOWN

11 If married, widowed, or divorced Fannie (unknown)
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 84 Years 3 Months 17 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Merchant
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 032-05-7824

16 BIRTHPLACE (City) Unknown
(State or country) Russia

17 NAME OF FATHER Samuel Goodman

18 BIRTHPLACE OF FATHER (City) -
(State or country) Russia

19 MAIDEN NAME OF MOTHER Rebecca Lomd

20 BIRTHPLACE OF MOTHER (City) -
(State or country) Russia

21 Informant Anne Siegal

(Address) 49 Boylston St. Malden, Mass.

A TRUE COPY Attest: Nathan J. Schneidman
(Registrar of City or Town where death occurred)

DATE FILED 10/2/67

MARGIN RESERVED FOR BINDING

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

DATE OF DISCHARGE

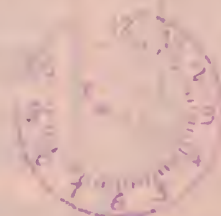
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

OCT 4 '67 AM



11-10-67 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

Essex
(County)

Danvers
(City or Town)

No. Danvers State Hospital

2 FULL NAME Mabel Carty (Ricker)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 79 Summit Avenue
(Usual place of abode)

Length of stay: In place of death... years 5 months 18 days. In place of residence... years months days.

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Danvers
(City or town making return)

Registered No.

{(If death occurred in a hospital or institution, give its NAME instead of street and number)

{(Was deceased a U. S. War Veteran, if so specify WAR) No

St. Winthrop, Mass.
(If nonresident, give city or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 2, 1967
(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 cardio-respiratory failure
due to coronary sclerosis - following vertebral fx

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury March 7 19 67

If accidental, was injury causally related to the death? No

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 Fell on floor
(How did injury occur?)

Nature of injury Ex lumbar vertebra

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) Dougald C. MacGillivray, M. D.
(Address) 10 Berry St., Danvers 10/2/67

7 Winthrop Cemetery Winthrop
Place of Burial, or Cremation (City or Town)

DATE OF BURIAL October 4 1967

8 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed OCT 18 1967

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX female 10 COLOR white 11 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widowed

11a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of unknown (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 90 Years 1 Months 4 Days If under 24 hours Hours Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 012-10-8570-D

17 BIRTHPLACE (City) Boston
(State or country) Mass.

18 NAME OF FATHER Ansel Ricker

19 BIRTHPLACE OF FATHER (City) Somersworth
(State or country) New Hampshire

20 MAIDEN NAME OF MOTHER unknown

21 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

22 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY.

ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED October 6 19 67

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

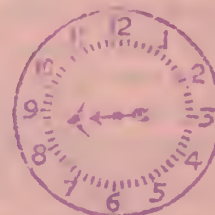
DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

OCT 18 67



IVAN CLERK
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MY

FORM R-301

The Commonwealth of Massachusetts

219

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

Suffolk
(County)Winthrop
(City or Town)

No. 37 Court Road

STANDARD
CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No2 FULL NAME Marion A. Dealy
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 37 Court Road St. Winthrop
(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 Oct. 4, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Feb. 10, 1963 to Oct. 4, 1967.I last saw her alive on Oct. 3, 1967 death is said to
have occurred on the date stated above, at 7:13 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis 12 hrs.

Due To Angina Pectoris 4 yrs.

(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?
If so, specify

(Signature) Charles J. Ferrera M.D.

Charles J. Ferrera MD
(Print or Type Name)

(Address) Winthrop Mass. Date 10-5-1967

6 Winthrop Winthrop Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 7, 1967

7 NAME OF FUNERAL DIRECTOR Harvey P. Morrison

ADDRESS 13 Yale Ave. Wakefield Mass.

Received and filed OCT 6 1967

A TRUE COPY ATTEST:

Registrar

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 63 Years 1 Months 28 Days If under 24 hours
Hours Minutes13 Usual Occupation School teacher
(Kind of work done during most of working life)

14 Industry or Business: Public school

15 Social Security No. None

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

17 NAME OF FATHER William F. Dealy

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Ellen M. Moriarty

20 BIRTHPLACE OF MOTHER (City) South Boston
(State or country) Mass.

21 Informant Paul B. Dealy

(Address) 65 Perkins St. Stoneham Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip J. Vitagliano
(Signature of Agent of Board of Health or other)Dir. of Public Health 10/5/67
(Official Designation) (Date of Issue of Permit)

PLACE OF DEATH

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).

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

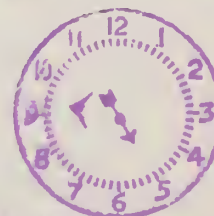
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 6 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

mv

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

211

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

STANDARD
CERTIFICATE OF DEATH

Registered No.

No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME ANNA G (WHITE) WADLAND
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 30 BOWDOIN STREET St. WINTHROP
(City or town and State)

Length of stay: In place of death.....years.....2 months 22 days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 4, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased, from JAN. 1963, to Oct. 4, 1967

I last saw her alive on 10/4/1967, death is said to have occurred on the date stated above, at 3:52 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer Rt. BREAST

INTERVAL BETWEEN ONSET AND DEATH 34 yrs.

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Operative

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) CHARLES L. LIVERMAN, M. D.

(Print or Type Name)

(Address) WINTHROP, MASS. Date 10/4/1967

6 Wintthrop Wintthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 7 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Lagrange

ADDRESS 147 Wintthrop St Wintthrop

Received and filed OCT 6 1967

A TRUE COPY ATTEST:

(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 GEORGE J WADLAND (Husband's name in full)

12 AGE 63 Years 8 Months 15 Days If under 24 hours

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business at Home

15 Social Security No. 024-28-8480

16 BIRTHPLACE (City) Chelsea (State or country) Mass

17 NAME OF FATHER John J White

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Catherine Hennessey

20 BIRTHPLACE OF MOTHER (City) Chelsea (State or country) Mass

21 Informant George W Wadland

(Address) 15 James Ave Wintthrop

PARENTS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip A. Vitagliano (M.D.) (Signature of Agent of Board of Health or other)

Director of Public Health 10-6-67 (Official Designation)

(Date of Issue of Permit)

PRINT 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 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).

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

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. 212

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 636 Pleasant St.

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Katherine Ciampa. (Bianco)
(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. 636 Pleasant St.

St. (City or town and State)

Length of stay: In place of death 17 years.....months.....days. In place of residence 17 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 5 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Feb 6 1967, to Oct 5 1967.I last saw her alive on Oct 1 1967; death is said to
have occurred on the date stated above, at 6:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Multiple Sclerosis 20 yrs

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Bil. Basal Pneumonia 2 mos.

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. G. Potito, M. D.

(Print or Type Name)

(Address) 179 Bennington St. E. Boston Date 10/5/67

6 Holy Cross, Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 7 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St. E. Boston

Received and filed OCT 6 1967

A TRUE COPY ATTEST:

(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 Joseph A. Ciampa
(Husband's name in full)12 AGE 52 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. C. B. L.

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF FATHER Nicholas Bianco

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Catherine McNahon

20 BIRTHPLACE OF MOTHER (City) Salem
(State or country) Mass.

21 Informant Mr. Joseph A. Ciampa-hus.

(Address) 636 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:Philip G. Vitariano
(Signature of Agent of Board of Health or other)Dir. of Public Health 10/5/67
(Official Designation) (Date of Issue of Permit)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).

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 6 '67 AM



CLERK OF THE TOWN CLERK
 WINTHROP, MASS.

mx

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

Registered No. 213

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

Emilia Haggstrom

(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.

72 Eustis

St.

Cambridge

(City or town and State)

Length of stay: In place of death 14 months days. In place of residence 3 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 9 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased, from
Aug. 1966, to Oct. 9 1967I last saw her alive on Oct. 5 1967, death is said to
have occurred on the date stated above, at 2:53 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion

Due To (b) Myocardial heart

Due To (c)

OTHER SIGNIFICANT CONDITIONS
Arteriosclerosis
Gen

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 H. Magrath, M. D.

(Print or Type Name)

(Address) 15 Washington St. Date 10/9/1967

Mt. Hope Boston

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 12 1967

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS East Boston

Received and filed OCT 11 1967

A TRUE COPY ATTEST:

(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

(or) WIFE of Otto H. Haggstrom
(Give maiden name of wife in full)
(Husband's name in full)12 AGE 84 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. C.N.B.L.

16 BIRTHPLACE (City) FINLAND
(State or country)

17 NAME OF FATHER CARL FAGERHOLM

18 BIRTHPLACE OF FATHER (City) FINLAND
(State or country)

19 MAIDEN NAME OF MOTHER CLARA JOANNA - - -

20 BIRTHPLACE OF MOTHER (City) FINLAND
(State or country)

21 Informant HELEN INDINGARO

(Address) 221 Paris 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:Philip G. Vitagliano, Jr.
(Signature of Agent of Board of Health or other)Div. of Public Health 10/11/67
(Official Designation)

(Date of Issue of Permit)

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).

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

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.

214

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 Anna Blangio (DeCristoforo)
(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. 144 St. Andrew Rd. East Boston, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....20 days. In place of residence.....35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 13 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1967, to 10/13, 1967.
I last saw him alive on 10/12, 1967 death is said to have occurred on the date stated above, at 5:20 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Heart

(b) Due To Death with a Blood

(c) Due To Branch Block

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) R. B. Pette, M. D.

(Print or Type Name)

(Address) 124 Bennington St. Date 10/13 1967

St. Michaels Cemetery, Boston

Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 16th 1967

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed OCT 13 1967

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 (Give maiden name of wife in full)

(or) WIFE of Albert R. Blangio (Husband's name in full)

12 AGE 75 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. No

16 BIRTHPLACE (City) Boston Mass. (State or country)

17 NAME OF FATHER Charles DeCristoforo

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Concetta Santuosso

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant Mr. Albert J. Blangio-son

(Address) 101 Bartlett St., Somerville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Velazquez (Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

to be filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATEPRINT 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 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).

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 13 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP MASS.

EB. Notified 11-7-67

MR-301A

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

Registered No. **215**No. *Viking Nursing Home*

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME *Thomas R. McGinnis*

(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. *51 Manning Rd.* St. *Lynn*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death *4* years *4* months *40* days. In place of residence *40* years *4* months *40* days.INSTRUCTIONS
FOR
L CERTIFICATE1 giving
S OF DEATH

1 not enter
1: than one
e for each
1 (b) and (c)

h does not mean
rle of dying,
heart failure,
etc. It means
ise, or compli-
which caused

ons, if any,
h gave rise to
ue cause (a),
in the under-
g cause last.

ons contrib-
death but not
the terminal
condition given

e. Chapter 137,
of 1954, requires
chs to print or
e cause or
f death on
ificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *Oct. 15 1967*
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from *July 1967* to *Oct. 15 1967*I last saw him alive on *Oct. 15 1967*, death is said to have occurred on the date stated above, at *8:40 P.M.*INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Myocardial Heart Disease*Due To (b) *arteriosclerosis
generalized*

Due To (c)

OTHER SIGNIFICANT CONDITIONS *Cirrhosis of liver & ascites*

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? *No*
If so, specify(Signed) *Joseph Spegare*, M. D.(Address) *194 Washington Ave* Date *Oct. 15 1967*6 Place of Burial or Cremation *Lynn* (City or Town)DATE OF BURIAL *Oct. 15 1967*7 NAME OF FUNERAL DIRECTOR *W. C. Parker*ADDRESS *Lynn Mass.*Received and filed *OCT 17 1967*

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *M* 9 COLOR *White* 10 SINGLE (write the word) *Widowed*
MARRIED
WIDOWED
or DIVORCED10a If married, widowed, or divorced HUSBAND of *Emma RAYMOND*
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE *86* Years Months Days If under 24 hours Hours Minutes13 Usual Occupation *Tacker*
(Kind of work done during most of working life)14 Industry or Business *Leather*15 Social Security No. *038-03-1223*16 BIRTHPLACE (City) *Peabody Mass.*
(State or country)17 NAME OF FATHER *John McGinnis*18 BIRTHPLACE OF FATHER (City) *Ireland*
(State or country)19 MAIDEN NAME OF MOTHER *Theresa Ready*20 BIRTHPLACE OF MOTHER (City) *Princ Edw. Island*
(State or country)21 Informant *Anna Bova*
(Address) *Lynn Mass.*

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip P. Vitaglione (P)
(Signature of Agent of Board of Health or other)*Director of Public Health 10/17/67*
(Official Designation) (Date of Issue of Permit)

50M-1-58-921876

A TRUE COPY ATTEST:

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

LYNN NOTIFIED 11-7-67

OCT 17 67 PM



OFFICE OF THE TOWN CLERK
WINTHROP MASS.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

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OCT 17 '67 PM



OFFICE OF TOWN CLERK
WINTHROP, MASS

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

217

Registered No.

STANDARD
CERTIFICATE OF DEATH

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 Sutherland Mae C. (BLACKBURN)
(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. 71 Grovers Ave. Winthrop

St. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....7.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 17 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Oct. 2, 19.67, to Oct 17, 19.67
I last saw him alive on Oct. 16, 1967 death is said to

have occurred on the date stated above, at 6:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

(b) arteriosclerosis gen.

Due To (c)

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS Cerebrovascular accident & left hemiplegia

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 E. Gregoire, M. D.

(Address) 194 W. Main St. Winthrop

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 19, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed OCT 18 1967

A TRUE COPY ATTEST: (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 Alexander Sutherland (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.

16 BIRTHPLACE (City) Gloucester Mass
(State or country)

17 NAME OF FATHER William Blackburn

18 BIRTHPLACE OF FATHER (City) Lancashire
(State or country) England

19 MAIDEN NAME OF MOTHER Elizabeth Hunt

20 BIRTHPLACE OF MOTHER (City) Lancashire
(State or country) England

21 Informant Paul T. Barry

(Address) 71 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:

Philip G. Vignola (Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

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).

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

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. 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

 JOHN C. VITAGLIANO
 (If deceased is a married, widowed or divorced woman, give also maiden name.)
 201 Cottage Park Road

 (Was deceased a
 U. S. War Veteran, no
 if so specify WAR)

(a) Permanent Residence. No. 201 Cottage Park Road

St. Winthrop

(City or town and State)

Length of stay: In place of death 7 years 0 months 0 days. In place of residence 41 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH October 18 1967
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
 Oct. 1966, to October 18, 1967
 I last saw him alive on Oct. 16, 1967, death is said to

have occurred on the date stated above, at 4:44 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial heart disease

(b) arteriosclerosis gen

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Joseph A. Gore M. D.

(Print or Type Name)

(Address) 19 Hoshing Ave. Date Oct. 18, 1967

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 21, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed OCT 20 1967

(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 Michela Sarno
 (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 83 Years 4 Months 7 Days If under 24 hours Hours Minutes

 13 Usual Occupation Retired Grocer
 (Kind of work done during most of working life)

14 Industry or Business Self-employed

15 Social Security No. 011-26-9077

 16 BIRTHPLACE (City) Avellino
 (State or country) Italy

17 NAME OF FATHER Carmen Vitagliano

 18 BIRTHPLACE OF FATHER (City) Italy
 (State or country)

19 MAIDEN NAME OF MOTHER Information Unavailable

 20 BIRTHPLACE OF MOTHER (City) Italy
 (State or country)

21 Informant Mrs. Dorothy Princi

 46 Bartlett Parkway, Winthrop
 (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

 Philip A. Vitagliano M.D.
 (Signature of Agent of Board of Health or other)

 Director of Public Health 10/20/67
 (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,
 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).

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.

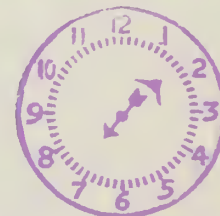
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

20 '67 PM



OFFICE OF THE TOWN CLERK
 WINTHROP, MASS.

177

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

219

Registered No.

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)

LOUISE (RAUSCH) LUTZE

2 FULL 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. 110 CIRCUIT ROAD

St. WINTHROP

(City or town and State)

Length of stay: In place of death _____ years _____ months 13 days. In place of residence 37 years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 19, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN, 1962, to Oct. 19, 1967.
I last saw her alive on Oct. 19, 1967, death is said to
have occurred on the date stated above, at 12:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Arteriosclerotic

INTERVAL
BETWEEN
ONSET AND
DEATH

5 yrs

Due To Heart Disease

(b) _____

Due To _____

(c) _____

OTHER
SIGNIFICANT
CONDITIONSAnemia
Pericolic Abscess

2 months

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 10/19/1967

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 23 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed OCT 20 1967

John B. Clark

(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 Frederick C Lutze
(Husband's name in full)12 AGE 83 Years 0 Months 15 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. 022-03-3217

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF FATHER Christian Rausch

18 BIRTHPLACE OF FATHER (City) Germany
(State or country)

19 MAIDEN NAME OF MOTHER Amelia Rudolph

20 BIRTHPLACE OF MOTHER (City) Germany
(State or country)

21 Informant Frederick C Lutze

(Address) 110 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:

Philip G. Vitagliano Jr.

(Signature of Agent of Board of Health or other)

Director of Public Health 10/20/67

(Official Designation)

(Date of Issue of Permit)

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 lost.Conditions contrib-
uting to death but not
related to the terminal
disease condition given
in (a).

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.

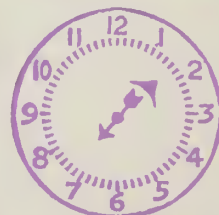
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

20 '67 PM



OFFICE OF THE TOWN CLERK

WINTHROP, MASS.

FORM R-303

filed for burial permit
by 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-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

WINTHROP

(City or Town making this return)

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No. 220

No. Viking Nursing Home

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}

2 FULL NAME LETITIA C HYDE
(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. 647 Saratoga St. East Boston
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....7.....days. In place of residence.....50.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 21, 1967
(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.
Acute 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, specify
(Signed) Michael A. Luongo, M.D.
(Address) Boston, Mass. Date 10/22 1967

7 Holy Cross Malden
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL Oct. 25 1967

8 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH
ADDRESS East Boston
OCT 24 1967

Received and filed John A. O'Brien 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 Widowed
12 If married, widowed, or divorced
HUSBAND Daniel Hyde (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)
13 AGE 86 Years. Months. Days If under 24 hours
Hours. Minutes
14 Usual Occupation: Housework
(Kind of work done during most of working life)
15 Industry or Business: Own Home
16 Social Security No. CNBL
17 BIRTHPLACE (City) Boston MASS.
(State or country)
18 NAME OF FATHER Michael FERREIRA
19 BIRTHPLACE OF FATHER (City) Virgin Islands
(State or country)
20 MAIDEN NAME OF MOTHER Margaret KEENAN
21 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)
22 Informant (Address) Margaret LeBlanc
256 MAIN ST. Medford

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Philip S. Vitagliano (w)
(Signature of Agent of Board of Health or other)
Director of Public Health 10/24/67
(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.)"

EX E B notified 11-7-67

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

Registered No. 221

STANDARD
CERTIFICATE OF DEATH

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

Michael Dattoli

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

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.)

196 Woodside Avenue

Winthrop

(a) Permanent Residence. No. St. (City or town and State)

Length of stay: In place of death years months 4 days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 22 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JAN. 1962 to Oct. 22, 1967I last saw him alive on Oct. 22, 1967, death is said to
have occurred on the date stated above, at 10:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion Acute 4 days

(b) Arteriosclerotic Heart 3 yrs.

(c) Disease —

INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
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) Charles Liberman M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 10/22/1967

6 Woodlawn Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 25 1967

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

9 Chelsea St., E. Boston, Mass.

ADDRESS

Received and filed OCT 23 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED married
UNKNOWN11 If married, widowed, or divorced HUSBAND of Mary Giggi
(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 Minutes13 Usual Occupation Shoe Worker
(Kind of work done during most of working life)

14 Industry or Business Copley Shoe

15 Social Security No. 011-03-7991A

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Ciriaco Dattoli

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Rosina Giorgia

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mary Dattoli (wife)

(Address) 196 Woodside 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:Philip G. Vitagliano
(Signature of Agent of Board of Health or other)Director of Public Health 10/23/67
(Official Designation) (Date of Issue of Permit)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 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).

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 23 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Danvers

(City or town making return)

Registered No. 222

No. Danvers State Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emily Silviera (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. 33 Forest St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years 1.....months 2.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 22, 1967 (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.)

Bronchopneumonia following operation for right hip fracture.

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury September 25 1967

If accidental, was injury causally related to the death? Yes

Where did injury occur? Hathorne, Mass. (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 Fell on floor (How did injury occur?)

Nature of injury Rt. hip fracture

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) Dougald C. MacGillivray, M. D.

(Address) 10 Berry St., Danvers 10/22/67

7 Calvary Cemetery Woburn (City or Town)

Place of Burial, or Cremation.

DATE OF BURIAL October 25 1967

8 NAME OF FUNERAL DIRECTOR Rogers Funeral Home

ADDRESS Cambridge, Mass.

Received and filed OCT 30 1967

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX female 10 COLOR white 11 SINGLE (write the word) MARRIED WIDOWED or DIVORCE widowed

11a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Silviera (or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 87 Years 8 Months 8 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. 016-40-9608-T

17 BIRTHPLACE (City) St. George (State or country) Azores

18 NAME OF FATHER Joseph Sears

19 BIRTHPLACE OF FATHER (City) Azores (State or country)

20 MAIDEN NAME OF MOTHER Mary Sears

21 BIRTHPLACE OF MOTHER (City) Azores (State or country)

22 Informant Helen A. Ziolkowski (Address) Danvers, Mass.

A TRUE COPY.

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED October 26 1967

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

OCT 30 '67 AM



WINTHROP, MASS

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop, Mass.
(City or Town making this return)

Suffolk

(County)

Winthrop, Mass.

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No. 223

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE2 FULL NAME Henry A. Farquhar, 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) W.W.2(a) Permanent Residence. No. 28 South Main St. Winthrop, Massachusetts
(City or town and State)

Length of stay: In place of death years months days. In place of residence 28 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 22, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan 21, 1950, to Oct 22, 1967
Last saw him alive on Oct 22, 1967, death is said to
have occurred on the date stated above, at 4:22 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE ANTERO-SEPTAL MYOCARDIAL INFARCTION 8 HRS.
(b) RT. BUNDLE BRANCH BLOCK 8 HRS.
(c) + VENTRICULAR FIBRILLATION 15 MIN.
ARTERIO-SCLEROTIC HEART DIS. 8 HRS.INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL + EKG

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) 28 Pleasant St. Winthrop, Mass. Date OCT 24, 19676 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 25, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed

OCT 25 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED MARRIED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Alice Grant
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 51 Years 9 Months 11 Days If under 24 hours
Hours Minutes13 Usual Occupation Machinist
(Kind of work done during most of working life)

14 Industry or Business: Lynn General Electric Co.

15 Social Security No. 013-01-3724

16 BIRTHPLACE (City) Boston Mass.
(State or country)

17 NAME OF FATHER Henry Adamson Farquhar, Sr.

18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)

19 MAIDEN NAME OF MOTHER Margaret MacKerron

20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)

21 Informant Mrs. Henry A. Farquhar

(Address) 28 So. 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:Philip S. DiGiorgio
(Signature of Agent of Board of Health or other)Winthrop Public Health 10/25/67
(Official Designation) (Date of Issue of Permit)be filed for burial permit
with Board of Health
or its Agent.PRINT 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,
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).

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 2-18-44

DATE OF DISCHARGE..... 12-27-45

RANK, RATING Machinist's Mate 3rd. Class

ORGANIZATION AND OUTFIT..... U.S. Navy

SERVICE NUMBER..... 803 73 88

.....

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.

MA

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop, Mass.
(City or Town making this return)

FORM R-301

Suffolk
(County)
Winthrop, Mass.
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 224

No. Winthrop Community Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Grady (McGuire)
(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. 10 Walley St. East Boston, Mass.
(City or town and State)

Length of stay: In place of death years months 1 days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 24 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 1965 to OCT 24 1967
I last saw him alive on OCT 24 1967, death is said to have occurred on the date stated above, at 6:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO-SCLEROTIC HEART DIS E CONGESTIVE FAILURE 6 MO
(b) Due To CHRONIC ASTHMATIC BRONCHITIS 3 YRS
(c) Due To EMPHYSEMA
INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS PERIPHERAL VASCULAR DIS 6 MO

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & X-ray

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) my pleasant St. Oct 24 1967
Winthrop, Mass.

WOODLAWN EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 27 1967

7 NAME OF FUNERAL DIRECTOR FREDERICK J. MAGRATH

ADDRESS East Boston

Received and filed OCT 26 1967

(Signature) John A. Carr (Registrar)

A TRUE COPY ATTEST:

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) ALEXANDER GRADY
(or) WIFE of (Husband's name in full)

12 AGE 67 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation HOUSEWORK
(Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. CNBL

16 BIRTHPLACE (City) Boston MASS
(State or country)

17 NAME OF FATHER Joseph MAGUIRE

18 BIRTHPLACE OF FATHER (City) CORK
(State or country) IRELAND

19 MAIDEN NAME OF MOTHER MARY E. Cunningham

20 BIRTHPLACE OF MOTHER (City) ALBANY N.Y.
(State or country)

21 Informant Ruth L. Ino

(Address) 12 Gladstone St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) Philip G. Vitagliano (mck)

(Official Designation) Director of Public Health (Date of Issue of Permit) 10/26/67

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 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).

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.

FORM R-301

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)

No.

WINTHROP COMMUNITY HOSPITAL

STANDARD
CERTIFICATE OF DEATH

Registered No.

225

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE2 FULL NAME RALPH SWARTZ
(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)

8 OAK STREET

(a) Permanent Residence. No.

St.

NATICK

(City or town and State)

Length of stay: In place of death.....years.....months.....10days. In place of residence.....11years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 26, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
June, 1967 to Oct. 26, 1967I last saw him alive on Oct. 26, 1967, death is said to
have occurred on the date stated above, at 11:40 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intestinal ObstructionDue To cause undetermined
(b)Due To
(c)OTHER SIGNIFICANT CONDITIONS Cerebrovascular Occlusion with Right HemiplegiaWas autopsy performed? NoWhat test confirmed diagnosis? Autopsy5 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 10/26/19676 Tifereth Israel of Winthrop, Everett

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Oct 29, 19677 NAME OF FUNERAL DIRECTOR Arnold GolovADDRESS 1668 Beacon St. BrooklineReceived and filed OCT 27 1967

A TRUE COPY ATTEST:

(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

Mary Disfriend

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 79 Years, 5 Months, 11 Days

If under 24 hours

.....Hours.....Minutes

13 Usual

Occupation Salesman

(Kind of work done during most of working life)

14 Industry

or Business: Retired15 Social Security No. 032-18-6641

16 BIRTHPLACE (City)

(State or country)

Russia

17 NAME OF

FATHER

Mayer Swartz

18 BIRTHPLACE OF

FATHER (City)

Russia

(State or country)

19 MAIDEN NAME

OF MOTHER

Molly Cohen

20 BIRTHPLACE OF

MOTHER (City)

Russia

(State or country)

21 Informant Ellis Swartz45 Oval Rd., Quincy

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitaraks

(Signature of Agent of Board of Health or other)

Director of Public Health10/27/67
(Date of Issue of Permit)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).

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

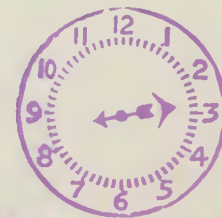
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 27 '67 PM



OFFICE OF
WINT

CLERK

Natick
Notified 11-7-67

FORM R-301

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. 226

ENROUTE TO WINTHROP COMMUNITY HOSP. (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME PHILIP KRAVETZ

(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. 106 GROVERS AVENUE

St. WINTHROP

(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 OCTOBER 23, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw him alive on 19....., death is said to
have occurred on the date stated above, at 9:30 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) natural causes, probably

(c) acute coronary occlusion on

OTHER SIGNIFICANT CONDITIONS
basis of history

Was autopsy performed Charles Liberman M.D.

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 10/23/1967

6 TIFERETH ISRAEL OF WINTHROP, EVERETT

Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCTOBER 24 67

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERV., INC.

ADDRESS 1615 BEACON ST., BROOKLINE

Received and filed OCT 23 1967

A TRUE COPY ATTEST:

(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 SADIE WINOKUR
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 65 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation TRUCKING CO. EXECUTIVE
(Kind of work done during most of working life)

14 Industry or Business: TRANSPORTATION

15 Social Security No. 034-14-3372

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER ABRAHAM ISAAC KRAVETZ

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER CELIA PEVIN

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

21 Informant ALLAN H. KRAVETZ (SON)

2 TEMPLE RD., LYNNFIELD

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)

This does not mean he mode of dying, such as heart failure, asthma, 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).

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 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 23 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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. 0851

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 Hilda W. Findlay (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) NO.

Apt. C 4 Viking Gardens

(a) Permanent Residence. No. 66 Shore Drive St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months. 5 days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 21, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
August 16, 1967, to August 21, 1967
I last saw her alive on August 21, 1967, death is said to
have occurred on the date stated above, at 2:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Accident

INTERVAL
BETWEEN
ONSET AND
DEATH

2 Days
Unknown
Years

(b) Aortic Stenosis

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NoWhat test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify C.C. Clay

(Signature) Charles L. Clay, M.D., M. D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Aug. 21, 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 23, 19677 NAME OF FUNERAL DIRECTOR Alfred B. MarshADDRESS 174 Winthrop Street, WintReceived and filed AUG 29 1967

A TRUE COPY ATTEST

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
divorced
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of David Findlay
(Husband's name in full)

12 AGE 85 Years 9 Months 29 Days If under 24 hours
Hours Minutes

13 Usual Occupation retired laundress
(Kind of work done during most of working life)

14 Industry or Business: Baptist Hospital15 Social Security No. 028-12-473616 BIRTHPLACE (City) Sweden
(State or country)17 NAME OF FATHER Carl Johnson18 BIRTHPLACE OF FATHER (City) Sweden
(State or country)19 MAIDEN NAME OF MOTHER Clara Sofia Johnson20 BIRTHPLACE OF MOTHER (City) Sweden
(State or country)

21 Informant Mrs. Thomas V. McClintock
(Address) Apt. C 4 Viking Gardens
Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
William J. Dane 12952
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

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
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).

General Director
Please use only
BLACK Ink.

A TRUE COPY ATTEST:

William J. Kane.
CLERK

Registered & Voted from 19 Moore St., Winthrop

112

DEC 6 '87 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

228

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. BETH ISRAEL HOSPITAL

STANDARD
CERTIFICATE OF DEATH

Registered No. 68490

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME HYMAN FISHMAN
(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. 380 SHIRLEY 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 AUG 30 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
8/15, 1967, to 8/30, 1967
I last saw him alive on 8/30/67, 1967, death is said to
have occurred on the date stated above, at 10:45 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Heart failure

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed?
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Richard K. Shirley, M. D.

RICHARD K. SHIRLEY
(Print or Type Name)

(Address) BETH ISRAEL HOSP. Date 8/30 1967

6 Beth Israel of Camb. Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 1, 1967

7 NAME OF FUNERAL DIRECTOR Paul R. Levine
ADDRESS 470 Harvard St., Brookline

Received and filed

SEP 6 1967

A TRUE COPY ATTEST:

(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 Edith Barrett
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 69 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation Dentist
(Kind of work done during most of working life)

14 Industry or Business: Dentistry

15 Social Security No. c/n/b/l/

16 BIRTHPLACE (City).....
(State or country) Rumania

17 NAME OF FATHER Solomon Fishman

18 BIRTHPLACE OF FATHER c/n/b/l/
(City)..... Rumania
(State or country)

19 MAIDEN NAME OF MOTHER Faige Barnett

20 BIRTHPLACE OF MOTHER c/n/b/l/
(City)..... Rumania
(State or country)

Mrs. Edith Fishman

21 Informant 380 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:Am. Can. 213012
(Signature of Agent of Board of Health or other)Sept 1 - 1967
(Official Designation) (Date of Issue of Permit)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 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).420.
81
x70

A TRUE COPY ATTEST:

William J. Kane.

Suffolk

(County)

Boston

(City or Town)

No. Veterans Administration Hospital

S.

FRED WOOD

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. Plymouth Mobile Park xx Plymouth, Mass.

(City or town and State)

Length of stay: In place of death.....years.....1 months.....4 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 7 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That VA attended deceased from August 4 1967 to September 7 1967

death is said to

have occurred on the date stated above, at 5:45 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

INTERVAL
BETWEEN
ONSET AND
DEATH
daysDue To
(b)Due To
(c)OTHER SIGNIFICANT CONDITIONS Carcinoma of lung
Necrotizing pancreatitis 1 yr wks.

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) H. Azmuden, M. D.

Kambiz Azmuden

(Print or Type Name)

(Address) VAH, Boston, Mass. Date Sept. 8 1967

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 11 1967

7 NAME OF FUNERAL DIRECTOR R. C. Kirby Funeral Home

ADDRESS 917 Bennington St., E. Boston, Mass.

Received and filed SEP 12 1967

A TRUE COPY ATTEST:

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

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, WWI
if so specify WAR)

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 Picard
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years 3 Months 20 Days

If under 24 hours
Hours Minutes

13 Usual Occupation Ferry Operator

(Kind of work done during most of working life)

14 Industry or Business City of Boston

15 Social Security No. 025-363-310-T

16 BIRTHPLACE (City) Newton
(State or country) Mass.

17 NAME OF FATHER Joseph Wood

18 BIRTHPLACE OF FATHER (City) Quebec
(State or country)

19 MAIDEN NAME OF MOTHER Virginia Delorey

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant VA Hospital Records, 150 So.
Huntington Ave., Boston, Mass.

(Address)

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)
E13373 Sept. 9, 1967
(Official Designation) (Date of Issue of Permit)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 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).

RECEIVED OCT 11 1967

William J. Kane.
City Registrar

OCT 5 1967 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

D-3
FORM R-303To 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.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,
§§ 47-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

DOM-9-63-936348

SUFFOLK

BOSTON

(City or Town)

En route to Massachusetts General Hospital

No.

FRANCIS

MELVILLE

2 FULL NAME

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

332 Bunker Hill Street, Charlestown

(a) Permanent Residence. No.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 28 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 11, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)
Acute myocardial infarction.

5 Accident, suicide, or homicide (specify)

Date and hour of injury.....19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

(Specify type of place)

Manner of
Injury

(How did injury occur?)

Nature of
Injury

While at work?.....Was autopsy performed?.....No.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) Michael A. Luongo, M.D.

Michael A. Luongo, M.D.

(Address) Boston (Print or Type Name) Date 9/11 67

7 Winthrop Cem. Winthrop
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Sept. 15 1967

8 NAME OF FUNERAL DIRECTOR John H. Sawyer

ADDRESS 329 Bunker Hill St. Charstn.

Received and filed SEP 15 1967

A TRUE COPY ATTEST:

(Registrar)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

Registered No. 08753

MEDICAL 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.) W.V.I.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE MARRIED (write the word)
WIDOWED
DIVORCED
UNKNOWN Married12 If married, widowed, or divorced
HUSBAND of Irene Mc Carthy
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)13 AGE 70 Years.....Months.....Days If under 24 hours
Hours.....Minutes14 Usual Occupation: Retired Dispatcher
(Kind of work done during most of working life)

15 Industry or Business: Boston Naval Shipyard

16 Social Security No. 021-01-5635

17 BIRTHPLACE (City) Charlestown
(State or country) Mass.

18 NAME OF FATHER Thomas Melville

19 BIRTHPLACE OF FATHER (City) UNKNOWN
(State or country)

20 MAIDEN NAME OF MOTHER Susan Howe

21 BIRTHPLACE OF MOTHER (City) Canada
(State or country)22 Informant Frene Melville
(Address) 332 Bunker Hill St. CharlestownI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with the BUREAU the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

E13576 9/13/67
(Official Designation) (Date of Issue of Permit)

ATTEST:

William J. Kene.
TOWN CLERK

DEC 6 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

xt

FORM R-301

OUT - OF - TOWN

SUFFOLK

(County)

CHELSEA

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

231

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

CHELSEA MEMORIAL HOSPITAL

No. _____ St. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number)

Registered No. 499

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH CYBULSKY
(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.1(a) Permanent Residence. No. 170 CLIFF AVE. 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 OCTOBER 14, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1967, to Oct 14, 1967.
I last saw him alive on Oct 14, 1967, death is said to have occurred on the date stated above, at 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE Myocardial Infarct(b) arteriosclerosis

(c) _____

OTHER SIGNIFICANT CONDITIONS

Pulmonary Hypertension

INTERVAL BETWEEN ONSET AND DEATH

36 hrs15 yrs4 yrsWas 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) William P. Finnegan M. D.
WILLIAM P. FINNEGAN M.D.(Address) 647 BROADWAY Date Oct 1967Woodlawn CHELSEA MASS
Place of Burial or Cremation Everett (City or Town)DATE OF BURIAL October 17, 19677 NAME OF FUNERAL DIRECTOR J. F. McGlinchey Funeral Home
By Richard F. NortonADDRESS 583 Broadway, ChelseaReceived and filed Oct 17, 1967

A TRUE COPY ATTEST:

(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 Loretta Branchosky
HUSBAND of Loretta Branchosky
(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 _____ Minutes13 Usual Occupation Machinest
(Kind of work done during most of working life)14 Industry or Business: Retired15 Social Security No. 034-05-737016 BIRTHPLACE (City) Poland
(State or country)17 NAME OF FATHER Martin Cybulsky18 BIRTHPLACE OF FATHER (City) Poland
(State or country)19 MAIDEN NAME OF MOTHER Cecelia ?20 BIRTHPLACE OF MOTHER (City) Poland
(State or country)21 Informant Mrs. Patricia A. AngeloIncl (Address) 1321 Main St. Reading

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) Donald F. Redington(Official Designation) Health Officer(Date of Issue of Permit) 10-16-67

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

9-20-17

DATE OF DISCHARGE.....

5-9-14

RANK, RATING.....

P-10

ORGANIZATION AND OUTFIT.....

U.S.A.

SERVICE NUMBER.....

165666F

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 un-
der any form of injury.

(2) Board of Health physicians will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance 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.

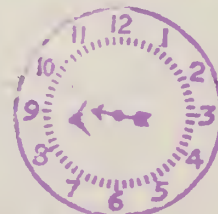
Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from 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.

A TRUE COPY ATTEST

John P. Doherty

City Clerk

NOV 30 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-302

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Revere

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH

Suffolk
(County)Revere
(City or Town)

No. Oceanview Manor Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME

Samuel Kaufman

(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. 37 Tewksbury

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 October 15, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan. 1950, to Oct. 15, 1967.
I last saw him alive on Oct. 15, 1967, death is said to
have occurred on the date stated above, at 11:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Arterio-
sclerotic Heart DiseaseDue 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.

(Address) Winthrop, Mass. Date 10/15/67

6 Montifore Society, Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 16, 1967

7 NAME OF FUNERAL DIRECTOR Torf Funeral Service, Inc.

ADDRESS 151 Washington Ave., Chelsea

Received and filed

NOV 20 1967

(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
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Mae Millen
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 86 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: Retired Plumber
(Kind of work done during most of working life)

14 Industry or Business Boston Elevated Street Rwy.

15 Social Security No. 024-10-2019

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Abraham Kaufman

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Bessie (C.B.L.)

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant William E. Kaufman

(Address) 37 Tewksbury St., Winthrop

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED October 16, 1967

MARGIN RESERVED FOR BINDING
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-5-64-938000

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

NOV 20 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

44

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Cambridge
 (City or Town where death occurred)

COPY OF
 CERTIFICATE OF DEATH

Registered No. 1497

(If death occurred in a hospital or institution,
 St. { give its NAME instead of street and number)

No. Holy Ghost Hospital, Cambridge

2 FULL NAME: Amelia Baxter
 (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. 97 Grovers Avenue St. Winthrop, Mass.
 (City or town and State)

Length of stay: In place of death, years 8 months 9 days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: October 16, 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
 Feb. 7, 1967, to October 16, 1967
 I last saw him live on October 16, 1967, death is said to
 have occurred on the date stated above, at 8:15 pm

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gram Negative Septicemia
 due to Chronic and Acute
 Pyelonephritis

(b) Subarachnoid Hemorrhage from

OTHER SIGNIFICANT CONDITIONS: Aneurysm with Rupture into
 Both Frontal Lobes

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.
 Holy Ghost Hospital

(Address) Cambridge, Mass. Date Oct. 17 67

6 Winthrop Cemetery, Winthrop
 Place of Burial or Crenation (City or Town)

DATE OF BURIAL: October 19 67

7 NAME OF FUNERAL DIRECTOR: Arthur J. O'Maley

ADDRESS: Winthrop, Mass.

Received and filed NOV 17 1967 S

(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 (Give maiden name of wife in full)

(or) WIFE of Ernest W. Baxter
 (Husband's name in full)

12 AGE: 55 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Beautician
 (Kind of work done during most of working life)

14 Industry or Business: Hair Dressing

15 Social Security No.
 16 BIRTHPLACE (City): Worcester
 (State or country) Mass.

17 NAME OF FATHER: Peter Carbone

18 BIRTHPLACE OF FATHER (City): Italy
 (State or country)

19 MAIDEN NAME OF MOTHER: Cannot be learned

20 BIRTHPLACE OF MOTHER (City): Italy
 (State or country)

21 Informant: Ernest W. Baxter

(Address) 97 Grovers Ave., Winthrop

A TRUE COPY: Thomas Morfhamara

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED: Oct. 18, 1967

MARGIN RESERVED FOR BINDING
 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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

NOV 17 '87 AM



OFFICE OF THE TOWN CLERK.
WINTHROP, MASS.

404

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.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Essex

(County)

Danvers

(City or Town)

No. Danvers State Hospital

2 FULL NAME Joseph Cushing
(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. 26 Center Street St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....year 2.....months 24.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 25, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Aug. 1, 1967, to October 25, 1967.
I last saw alive on October 25, 1967. Death is said to
have occurred on the date stated above, at 9:10 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardio-respiratory failure hrs.

Due To Arteriosclerotic heart disease yrs.

(b) Generalized arteriosclerosis yrs.

OTHER
SIGNIFICANT
CONDITIONS Cystitis

Was autopsy performed? No

What test confirmed diagnosis Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 10/26/67

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 30, 1967

7 NAME OF FUNERAL DIRECTOR O'Malley Funeral Home
Winthrop, Mass.
ADDRESS

Received and filed NOV 14 1967

(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 widowed11 If married, widowed, or divorced
HUSBAND of Mary Brennan
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 81 Years 5 Months 21 Days If under 24 hours
Hours Minutes13 Usual Occupation Retired
(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 017-10-0878

16 BIRTHPLACE (City) Newton
(State or country) Mass.

17 NAME OF FATHER Gardner Cushing

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Catherine Fennish

20 BIRTHPLACE OF MOTHER (City) P.E.I.
(State or country)21 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY

ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED October 30, 1967

MARGIN RESERVED FOR BINDING
WRITE 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

.....

NOTE: RESIDENCE,
170 Cliff Ave, Winthrop

NOV 14 87 AM



CLERK
WINTHROP, MASS.

2V

FORM R-301

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 mode of dying,
such as heart failure,
sthenia, 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

WINTHROP
(City or Town making this return)



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)

STANDARD
CERTIFICATE OF DEATH

Registered No.

235

2 FULL NAME MORRIS GLASS

(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

PHYSICIAN — IMPORTANT

(a) Permanent Residence. No. 20 MYRTLE AVENUE WINTHROP MASSACHUSETTS

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 28 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 3 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JAN 1967 to NOV 3 1967
I last saw him alive on Nov 3 1967, death is said to
have occurred on the date stated above, at 7:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 3 wks.

Due To (b) Arteriosclerotic Heart

Due To (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

(Print or Type Name)

(Address) WINTHROP, MASS. Date Nov. 3 1967

6 Jewish Deed Holders Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 5 1967

7 NAME OF FUNERAL DIRECTOR Solomon Funeral Home Inc

ADDRESS 420 Harvard St Brookline

Received and filed NOV 6 1967

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 Anna Weiseman
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 69 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 Dry Goods Store

15 Social Security No. 010-28-1385

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Herchel Glass

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Bessie Unknown

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Anna Glass (Wife)

(Address) 20 Myrtle Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 11/5/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

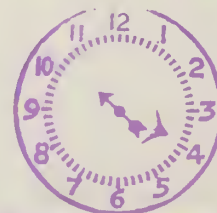
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV - 6 '67 PM



OFFICE OF THE TOWN CLERK
 WINTHROP MASS.

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. 236

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



No. 132 LOCUST WAY

(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

James F. McLaughlin

(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.

132 Locust Way

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

Nov. 6, 1967
(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 3:30 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To

(b) natural causes, probable an

Due to

(c) acute coronary occlusion on

basis of history

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?

If so, specify

(Signature) Charles Liberman, M. D.

(Address) WINTHROP, MASS. Date 11/7/1967

6 Winthrop Cem Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 9, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed NOV 8 1967

(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 CATHERINE E O'GARA

(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 STEAM FITTER

(Kind of work done during most of working life)

14 Industry

or Business GENERAL

15 Social Security No. 032-03-3295

16 BIRTHPLACE (City) NEWTON LOWER FALLS

(State or country) MASS

17 NAME OF

FATHER JOHN McLAUGHLIN

18 BIRTHPLACE OF

FATHER (City) IRELAND

(State or country)

19 MAIDEN NAME

OF MOTHER BRIDGET CAIN

20 BIRTHPLACE OF

MOTHER (City) IRELAND

(State or country)

21 Informant CATHERINE E McLAUGHLIN

(Address) 132 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:

Philip J. McLaughlin

(Signature of Agent of Board of Health or other)

Director of Public Health Nov. 8 1967

(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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FORM R-301

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. 237

No. Cliff House Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Arthur F Bowes

(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. 26 Sturgis St. (City or town and State)

Length of stay: In place of death years 2 months 11 days. In place of residence 55 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 7 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN. 52, 19.52, to NOV. 7, 1967.
I last saw him alive on NOV. 7, 1967, 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 5 yrs

(b) Due To

(c) Due To Generalized Arteriosclerosis 15 yrs

OTHER
SIGNIFICANT
CONDITIONS NoneWas autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 11/7/1967

6 Mt Hope Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 10 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed NOV 9 1967 19

A TRUE COPY ATTEST:

(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 Laura A Osborne
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 100 Years 5 Months 9 Days If under 24 hours
Hours Minutes13 Usual Occupation Engineer
(Kind of work done during most of working life)

14 Industry or Business City of Boston

15 Social Security No. None
16 BIRTHPLACE (City) Halifax
(State or country) Nova Scotia

17 NAME OF FATHER George Bowes

18 BIRTHPLACE OF FATHER (City) Halifax
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Elizabeth Turner

20 BIRTHPLACE OF MOTHER (City) Halifax
(State or country) Nova Scotia

21 Informant Francis Bowes

(Address) 1 Stonehill Drive Stoneham, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip S. Kesteven
(Signature of Agent of Board of Health or other)
Director of Public Health Nov 9/67
(Official Designation) (Date of Issue of Permit)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).

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.

NEW - 9 67 AM



OFFICE

WV

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. 238

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 MARGARET Mc MURRAY
 (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. 80 INGLESIDE AVE St. WINTHROP
 (City or town and State)

Length of stay: In place of death 3 years.....months.....days. In place of residence 42 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 7 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
 NOV 1940 to NOV 7 1967
 I last saw him alive on NOV 7 1967 death is said to
 have occurred on the date stated above, at 2 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) VIRUS PNEUMONIA 12 Days

Due To
 (b)

Due To SENILETY
 (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

(Signature) LOUIS F. SALEMA M. D.
 LOUIS F. SALEMA
 (Print or Type Name)

(Address) 175 PLEASANT ST. Date NOV 7 1967

6 WINTHROP WINTHROP
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 11 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP, MASS

Received and filed NOV 8 1967

(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 57 Years.....Months.....Days
 If under 24 hours
Hours.....Minutes

13 Usual OCCUPATION BOOKKEEPER
 (Kind of work done during most of working life)

14 Industry or Business AUTOMOBILE SALES

15 Social Security No. 023-09-5596

16 BIRTHPLACE (City) SCOTLAND
 (State or country)

17 NAME OF FATHER JOHN Mc MURRAY

18 BIRTHPLACE OF FATHER (City) SCOTLAND
 (State or country)

19 MAIDEN NAME OF MOTHER JANE MELLV

20 BIRTHPLACE OF MOTHER (City) SCOTLAND
 (State or country)

21 Informant MARY SWENDENMAN
 (Address) 80 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:
 Philip J. Vitagliano Jr.
 (Signature of Agent of Board of Health or other)
 Director of Public Health NOV 8 1967
 (Official Designation) (Date of Issue of Permit)

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,
 pneumonia, etc. It means
 the disease, or compli-
 cations which caused
 death.

Conditions, if any,
 which gave rise to
 above cause (a),
 stating the under-
 lying cause last.

Conditions contrib-
 uting to death but not
 related to the terminal
 disease condition given
 (a).

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.

11/11

FORM R-301

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 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).

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 19 Enfield Road

2 FULL NAME Agnes C. Corcoran (Molloy)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 19 Enfield Road

St. (City or town and State)

Length of stay: In place of death 30 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 9, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
11-29, 1965, to Nov. 9, 1967.
I last saw her alive on Nov. 9, 1967, death is said to
have occurred on the date stated above, at 4:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

(b) Arteriosclerosis - generalized

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

40

40

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 P. O'Regan, M. D.

(Print or Type Name)

(Address) 194 Washington St., Winthrop, Mass. Date 11-10-67

6 Holy Cross Malden, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 13, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed NOV 13 1967

(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. 239

{(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 William F. Corcoran (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. 16 BIRTHPLACE (City) South Boston, Mass
(State or country)

17 NAME OF FATHER Thomas F. Molloy

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary E. Phelan

20 BIRTHPLACE OF MOTHER (City) South Boston, Mass
(State or country)

21 Informant Mary Corcoran
(Address) 19 Enfield Road Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitochianakis
(Signature of Agent of Board of Health or other)

Dir. of Public Health 11/13/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

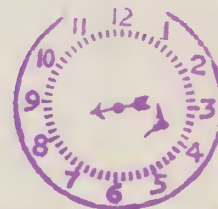
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 13 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Danvers

(City or town making return)

240

Registered No.

No. Danvers State Hospital

{(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

2 FULL NAME Catherine Kelleher (O'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) No

(a) Residence. No. 58 Somerset 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.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 9, 1967
(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 cardio-respiratory failure
presumably due to arteriosclerotic
ht disease &/or pulmonary embolus

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury June 13 19 67

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? Nursing Home
(Specify type of place)Manner of injury Fell out of restraining chair
(How did injury occur?)

Nature of injury Fracture L hip

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) Dougald C. MacGillivray M. D.
(Address) 10 Berry St., Danvers 11-9-677 Holy Cross Cemetery Malden
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL November 11 19 67

8 NAME OF FUNERAL DIRECTOR McGrath Funeral Home
ADDRESS Malden, Mass.

Received and filed NOV 27 1967

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX female 10 COLOR white 11 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widowed

11a If married, widowed, or divorced HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Dennis J. Kelleher
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 90 Years 9 Months 23 Days If under 24 hours Hours Minutes

14 Usual Occupation: Housework
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 023-24-6933-D

17 BIRTHPLACE (City) Boston
(State or country) Mass.

18 NAME OF FATHER William O'Grady

19 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

20 MAIDEN NAME OF MOTHER unknown

21 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)22 Informant Helen A. Ziolkowski
(Address) Danvers, Mass.

A TRUE COPY.

ATTEST: Daniel Toomey
(Registrar of City or Town where death occurred)

DATE FILED November 14 19 67

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

NOV 27 '67 AM



OFFICE
WILSON

MX

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

PLACE OF DEATH

DOFFOLLY
(County)WINTHIPOD
(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 241

No. 2 BURRILL TERRACE

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME EDITH M WOODS (BARKER)
(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. 2 BURRILL TERRACE St. WINTHIPOD
(Usual place of abode)

(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 Nov. 10, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Sept 8, 1967, to Nov. 10, 1967

I last saw her alive on Nov. 8, 1967, death is said to

have occurred on the date stated above, at 3:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma metastasis

(b) Carcinoma of Lung

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

weeks

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 C. R. GREGG, M. D.

(Print or Type Name)

(Address) 194 Woodbury Ave Date 1-13 1967

6 WINTHIPOD WINTHIPOD
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 13 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHIPOD, MASS.

Received and filed NOV 13 1967

John A. Clare

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED

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 35 Years. Months. Days If under 24 hours Hours Minutes

13 Usual Occupation RECEPTIONIST.
(Kind of work done during most of working life)

14 Industry or Business HOTEL

15 Social Security No.

16 BIRTHPLACE (City) WINTHIPOD
(State or country) MASS

17 NAME OF FATHER JAMES BARKER

18 BIRTHPLACE OF FATHER (City) EVERETT Winthrop
(State or country) MASS

19 MAIDEN NAME OF MOTHER HILMA HALLETT

20 BIRTHPLACE OF MOTHER (City) EVERETT Chelsea
(State or country) MASS21 Informant CHARLES W. WOODS
(Address) 2 BURRILL TER WINTHIPOD

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vitagliano B.

(Signature of Agent of Board of Health or other)

Director of Public Health 11/13/67
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

ed for burial permit
Board of Health
or its Agent.INSTRUCTIONS
FOR
AL CERTIFICATEIT OR TYPE
E OR CAUSES
F DEATHnot enter
re than one
se for each
, (b) and (c)does not mean
ode of dying,
s heart failure,
a, etc. It means
case, or compli-
which causeditions, if any,
ave rise to
cause (a),
g the under-
cause last.ditions contrib-
o 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.

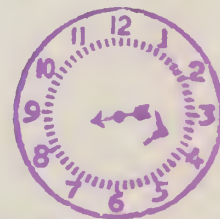
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

NOV 13 67 PM



OFFICE OF THE CITY CLERK
WINTHROP, MASS.

FORM R-301

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,
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
disease condition given
(a).

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. 242

PLACE OF DEATH
SUFFOLK
(County)
WINTHROP
(City or Town)
No. 454 Shirley St.

1 FULL NAME RALPH R. GOLDBURGH
(If deceased is a married, widowed or divorced woman give also maiden name.)

(a) Permanent Residence. No. 117 COURT ROAD St. WINTHROP
(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 NOV. 12, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 1960, to NOV. 11, 1967.

1 last saw him alive on NOV. 11, 1967, death is said to have occurred on the date stated above, at 6:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 10 min

(b) Hypertensive Arterio 7 yrs.

(c) Sclerotic Heart Disease

OTHER SIGNIFICANT CONDITIONS Congestive Heart Failure 3 mos.

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 11/12/1967

6 MISHKAN TEFILA; West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV. 14, 1967

7 NAME OF FUNERAL DIRECTOR MORRIS W. BREZNIAK

ADDRESS 470 HARVARD ST, BROOKLINE

Received and filed NOV 14 1967

John A. Clare (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 BEATRICE WEINER
(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 PHARMACIST
(Kind of work done during most of working life)

14 Industry or Business: PHARMACY

15 Social Security No. UNKNOWN

16 BIRTHPLACE (City) Somerville MASS.
(State or country)

17 NAME OF FATHER MAX GOLDBURGH

18 BIRTHPLACE OF FATHER (City) LATVIA
(State or country)

19 MAIDEN NAME OF MOTHER BESSIE PEARLMAN

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

21 Informant MRS. BEATRICE GOLDBURGH
(Address) 117 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:

Philip D. Vitagliano
(Signature of Agent of Board of Health or other)
Dir. of Public Health NOV 14, 1967
(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

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

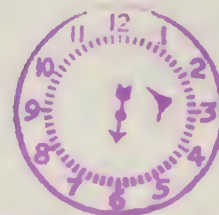
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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 14 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

FORM R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No.

Winthrop Com Hospital

STANDARD
CERTIFICATE OF DEATH

Registered No. 243

If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ingersoll Marie T. (McLAUGHLIN)
(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. 34 Enfield Rd. St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death years months 5 days. In place of residence 46 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 13 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 20 1959 to Nov. 13 1967I last saw her alive on NOVEMBER 13 1967, death is said to
have occurred on the date stated above, at 10:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE
WITH LEFT HEMIPLEGIA 5 DAYS(b) HYPERTENSIVE & ARTERIO-
SCLEROTIC HEART DISEASE 5 YRS(c) GENERALIZED ARTERIO-
SCLEROSIS 10 YRSOTHER SIGNIFICANT CONDITIONS CHRONIC CHOLECYSTITIS
CHOLELITHIASIS 5 YRSWas 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. TRANENSTEIN M. D.

(Address) 73 BARTLETT RD. Date Nov. 13 1967
WINTHROP, MASS6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 17 1967

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS 210 Winthrop St Winthrop

Received and filed NOV 18 1967

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of David F Ingersoll
(Husband's name in full)12 AGES 24 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Homemaker
(Kind of work done during most of working life)

14 Industry or Business AT Home

15 Social Security No. 010-24-4949 A

16 BIRTHPLACE (City) BOSTON
(State or country) Mass

17 NAME OF FATHER William J McLaughlin

18 BIRTHPLACE OF FATHER (City) SANDWICH
(State or country) MASS

19 MAIDEN NAME OF MOTHER MARY A OURLY

20 BIRTHPLACE OF MOTHER (City) ENGLAND
(State or country)21 Informant MRS VIRGINIA McGRATH
(Address) 34 ENFIELD RD WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. V. (Signature of Agent of Board of Health or other)

Nov 16 1967 (Date of Issue of Permit)

(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 STATISTICSWINTHROP
(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 244

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 ANITA (COHEN) SADORF

(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 FAUN BAR AVENUE

St. WINTHROP

(City or town and State)

Length of stay: In place of death.....years. 2 months. 6 days. In place of residence. 11 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOVEMBER 14, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN 1952 to NOV 14, 1967I last saw him alive on NOV 14, 1967, death is said to
have occurred on the date stated above, at 2:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis due

Due To to Primary Carcinoma

(b) of colon

(c)

OTHER
SIGNIFICANT
CONDITIONS

None

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 11/14/1967

6 TIFERETH ISRAEL of Wintthrop, EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 16, 1967

7 NAME OF FUNERAL DIRECTOR Philip BRiss

ADDRESS 470 HARVARD ST. Brookline

Received and filed NOV 15 1967

John A. Clark

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
WIDOW
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

MURRAY SADORF

(Husband's name in full)

12

AGE 61 Years - Months - Days

If under 24 hours

Hours - Minutes

13 Usual

Occupation

SALES

(Kind of work done during most of working life)

14 Industry

or Business:

CLOTHING

15 Social Security No.

015-24-2707

16 BIRTHPLACE (City)

NEW YORK

(State or country)

P

A

R

E

N

T

S

17 NAME OF

FATHER

SAMUEL COHEN

18 BIRTHPLACE OF

FATHER (City)

ENGLAND

(State or country)

19 MAIDEN NAME

OF MOTHER

ROSE LEVY

20 BIRTHPLACE OF

MOTHER (City)

NEW YORK

(State or country)

21 Informant

Joseph Bloom

(Address)

82 SHARPE RD, Newton, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)

Director of Public Health 11/5/67

(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.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

Essex

(County)

Danvers

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 245

No. Danvers State Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Martin Weisberg

(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. 43 Hutchinson Street St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 28 years 5 months 0 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 14, 1967

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 30, 1961, to November 14, 1967
I last saw him live on November 14, 1967 death is said to
have occurred on the date stated above, at 7:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion mins.

(b) Due To Arteriosclerotic heart disease yrs.

(c) Due To Generalized arteriosclerotic yrs.

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 11-15-67

6 Woodlawn Cemetery Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 16, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh Funeral Home

ADDRESS Winthrop, Mass.

Received and filed NOV 27 1967

(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 53 Years 1 Months 21 Days If under 24 hours
Hours Minutes13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. None

16 BIRTHPLACE (City) Belmont
(State or country) Mass.

17 NAME OF FATHER George J. Weisberg

18 BIRTHPLACE OF FATHER (City) New York
(State or country)

19 MAIDEN NAME OF MOTHER Mary Davis

20 BIRTHPLACE OF MOTHER (City) New Jersey
(State or country)

21 Informant Helen A. Ziolkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED November 17, 1967

MARGIN RESERVED FOR BINDING

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

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

NOV 27 '67 AM



OFFICE OF THE GOVERNOR
WINTHROP, MASS.

for burial permit
and of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

not enter
than one
for each
(b) and (c)

es not mean
of dying,
heart failure,
etc. It means
e, or compli-
which caused

ns, if any,
ave rise to
cause (a),
the under-
cause last.

tions contrib-
death but not
the terminal
condition given

PLACE OF DEATH

Suffolk (County)

Winthrop (City or Town)

No. 41 Shirley

2 FULL NAME Thomas B Marshall
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 41 Shirley
(Usual place of abode)

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 NOV 16 1967
(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 3:25 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due To natural causes, with

(c) Due To history of amyotrophic

(d) Due To lateral sclerosis.

OTHER SIGNIFICANT CONDITIONS WINTHROP BOARD OF HEALTH
Charles Liberman MD

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 11/16/1967

6 Winthrop Winthrop Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 20 1967

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed NOV 20 1967 19

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

WINTHROP

(City or Town making this return)

Registered No. 246

{(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) H.W.1

Winthrop Mass

(City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Divorced11 If married, widowed or divorced
HUSBAND of Eileen Hayes
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 71 8 19
AGE... Years... Months... Days If under 24 hours
Hours... Minutes13 Usual Occupation Constable
(Kind of work done during most of working life)

14 Industry or Business Town Of Winthrop

15 Social Security No. 033-07-4446

16 BIRTHPLACE (City) Melrose Mass
(State or country)

17 NAME OF FATHER Norman Kelley

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) unknown
(State or country)21 Informant Mrs Barbara Hughes
(Address) 41 Shirley St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vito (Signature of Agent of Board of Health or other)
Director of Public Health 11/20/67
(Official Designation) (Date of Issue of Permit)

Med. Examiner notified - Referred to Board of Health

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE..... June 7 1917
 DATE OF DISCHARGE..... June 6 1921
 RANK, RATING..... Seaman 2nd Class
 ORGANIZATION AND OUTFIT..... Navy
 SERVICE NUMBER..... 141-73-32.

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.

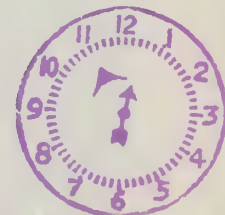
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

JUN 20 '67 AM



OFFICE OF THE
 MUNICIPAL

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE. June 24, 1918

DATE OF DISCHARGE..... Dec. 11, 1918

RANK, RATING Pvt.

ORGANIZATION AND OUTFIT. 1st Co. 1st Rec. Bn. 151st Depot Brigade Army

SERVICE NUMBER..... 2726654

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

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. 248

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 WILLIAM A. 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) NO.

 (a) Permanent Residence. No. 271 River Road St. Winthrop, Mass.
 (City or town and State)

Length of stay: In place of death.....years.....months10.....days. In place of residence. 60.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH 11-19-67
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY That I attended deceased from
 Dec 60 to 11-19-67

 I last saw him alive on 11-18-67 death is said to
 have occurred on the date stated above, at 6:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) pneumonia

(b) Due To chronic nephritis

(c) Due To

OTHER SIGNIFICANT CONDITIONS

 Was autopsy performed? NO
 What test confirmed diagnosis? B.U.N.

 5 Was disease or injury in any way related to occupation of deceased? NO
 If so, specify

(Signature) H. B. Greenfield, M. D.

 447 Church (Print or Type Name)
 (Address) Winthrop Date 11-19-67

 6 Winthrop Cemetery, Winthrop, Mass.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 21, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed NOV 20 1967

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 Christine McCarthy
 (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

 12 AGE 88 Years 1 Months 4 Days If under 24 hours
 Hours Minutes

 13 Usual Occupation retired postman
 (Kind of work done during most of working life)

14 Industry or Business: U.S. Post Office Dept.

15 Social Security No. none

 16 BIRTHPLACE (City) Boston
 (State or country) Massachusetts

17 NAME OF FATHER Michael Grimes

 18 BIRTHPLACE OF FATHER (City) Charlestown
 (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Sophie Burgess

 20 BIRTHPLACE OF MOTHER (City) Charlestown
 (State or country) Massachusetts

21 Informant Mrs. William A. Grimes

(Address) 271 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:

 (Signature of Agent of Board of Health or other)
 Director of Public Health 11/20/67
 (Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 '67 PM



OFFICE C. TOWN CLERK
WINTHROP, MASS.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)

FORM R-301

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 249

No. 20 WAVE WAY

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

CELIA (GOLDBERG) FOGEL

(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 WAVE WAY AVE. WINTHROP, MASS
(City or town and State)

Length of stay: In place of death 58 years months days. In place of residence 58 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 20 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN. 1950, to NOV. 20 1967.I last saw her alive on Nov. 18 1967, death is said to
have occurred on the date stated above, at 8:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart

Due To Disease

Due To

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 11/20/1967

6 THERESA ISRAEL of WINTHROP, EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV. 21 1967

7 NAME OF FUNERAL DIRECTOR TORI-FUNERAL SERVICE INC

ADDRESS 157 WASHINGTON ST. CHASE

Received and filed NOV 20 1967

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN11 If married, widowed, or divorced
HUSBAND of(or) WIFE of JOSEPH D. FOGEL
(Give maiden name of wife in full)
(Husband's name in full)12 AGE 82 years Months Days If under 24 hours
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) LITHUANIA
(State or country)

17 NAME OF FATHER EPHRAIM ISAAC GOLDBERG

18 BIRTHPLACE OF FATHER (City) LITHUANIA
(State or country)

19 MAIDEN NAME OF MOTHER ZIPPOPH (CBL)

20 BIRTHPLACE OF MOTHER (City) LITHUANIA
(State or country)

21 Informant Miss FRANCES FOGEL

20 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:Philip G. Vitoskano
(Signature of Agent of Board of Health or other)Div. of Public Health Nov 20 1967
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 20 '67 PM



OFFICE OF TOWN CLERK
WINTHROP, MASS.

for burial permit
ard of Health
ts 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,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
condition given

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 250

Suffolk

(County)

Winthrop

(City or Town)

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 Ethel Preble
(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 Lowell Road, Winthrop, Mass. St.
(Usual place of abode)

(City or town and State)

Length of stay: In place of death 0 years 2 months 27 days. In place of residence 23 years 1 months 1 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 25, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 8, 1967, to Nov. 25, 1967.

I last saw him alive on November 24, 1967, death is said to
have occurred on the date stated above, at 10.30A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic Carcinoma

Due To Adenocarcinoma of Left Breast

Due To
(b)
(c)

OTHER
SIGNIFICANT
CONDITIONS None

INTERVAL
BETWEEN
ONSET AND
DEATH
9 Mos.

Was autopsy performed? No
What test confirmed diagnosis? Pathology Report

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signature) John F. Collins M.D.

John F. Collins M.D.
(Print or Type Name)

(Address) Revere, Mass. Date Nov. 25, 1967

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 28, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed NOV 28 1967

John C. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, divorced or unknown, give name of spouse in full

(or) WIFE of Frederick P. Preble
(Husband's name in full)

12 AGE 69 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 Home

15 Social Security No. 011-01-7752-B

16 BIRTHPLACE (City) Southbridge Mass
(State or country)

17 NAME OF FATHER Michael Kelly

18 BIRTHPLACE OF FATHER (City) Jamaica Plain Mass
(State or country)

19 MAIDEN NAME OF MOTHER Sarah Beals

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Frederick P. Preble
(Address) 10 Lowell Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip P. Vitagliano Jr.
(Signature of Agent of Board of Health or other)
Dir. of Public Health 1/28/67
(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.

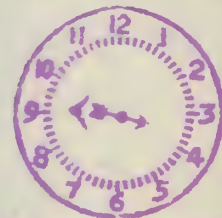
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(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.

28 67 PM



OFFICE
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1932

MV

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, MASS

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 251

1

PLACE OF DEATH

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 GERTRUDE J. (WALSH) CROWLEY

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, 110
if so specify WAR)

(a) Permanent Residence. No. 43 Loring Rd., Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 10 days. In place of residence 30 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 26 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov. 16, 1967, to Nov. 26, 1967I last saw her alive on Nov. 25, 1967, death is said to
have occurred on the date stated above, at 6:48 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion

(b) Due to Atherosclerosis - gen yrs

(c) Due To

OTHER SIGNIFICANT CONDITIONS Atherosclerotic heart disease yrs

Was autopsy performed? no

What test confirmed diagnosis? ~~no~~5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph J. Regan, M. D.

(Print or Type Name)

(Address) 194 Washington St. Date Nov. 26, 1967

6 Winthrop Cem. Winthrop.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 29, 1967

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Winthrop St.

Received and filed NOV 29 1967

John H. Clark

(Registrar)

A TRUE COPY ATTEST:

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 F. Crowley

(Husband's name in full)

12 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: Home

15 Social Security No. 013-07-3523-A

16 BIRTHPLACE (City) East Boston
(State or country)

17 NAME OF FATHER Thomas A. Walsh

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Murray

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country)

21 Informant Mrs. Robert Remington

(Address) 18 Tamarack Rd. Medford

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip S. Vasilopoulos, Jr.
(Signature of Agent of Board of Health or other)Dir. of Public Health 11/29/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 29 '67 AM



OFFICE OF THE CLERK
 WINTHROP, MASS.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

252

Registered No.

Suffolk

(County)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

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 Fannie Alean Swift (Whittle)

(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. 192 Bartlett Road

(City or town and State)

Length of stay: In place of death, 3 years, 3 months, 3 days. In place of residence, 4 years, 4 months, 4 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 26 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Jan 14, 1967, to Nov 26, 1967I last saw him alive on Nov 26, 1967 death is said to
have occurred on the date stated above, at 10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Broncho pneumoniaINTERVAL
BETWEEN
ONSET AND
DEATH2 days

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSfracture hip 7-26-67Was 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. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Starkey St. Winthrop Date 11-26 19676 Winthrop Cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 29, 19677 NAME OF FUNERAL DIRECTOR Alfred B. MarshADDRESS 174 Winthrop St. Winthrop, Mass.Received and filed NOV 28 1967

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED widowed

WIDOWED

DIVORCED

UNKNOWN

female white

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Ralph Aloysius Swift

(Husband's name in full)

12

AGE 82 years, 5 months, 16 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 home15 Social Security No. 017-40-3740 J.I.

16 BIRTHPLACE (City)

(State or country)

ChelseaMassachusetts

17 NAME OF

FATHER

Charles Phillip Whittle

18 BIRTHPLACE OF

FATHER (City)

Charlestown

(State or country)

Massachusetts

19 MAIDEN NAME

OF MOTHER

Helen M. Blaisdell

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Maine

21 Informant

Paul Swift

(Address)

192 Bartlett RoadI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip E. Detagliasio (mek)

(Signature of Agent of Board of Health or other)

Director of Public Health
(Official Designation)11/28/67
(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.

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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 28 '67 PM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS

FORM R-301

The Commonwealth of Massachusetts

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. 253

 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 Samuel Aloff (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 GLENARM ST. St. DORCHESTER
 (City or town and State)

 Length of stay: In place of death.....years.....months.....21 days. In place of residence.....2 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH November 27, 1967
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
Aug, 1966, to Nov. 27, 1967

 I last saw him alive on 11/27, 1967, death is said to
 have occurred on the date stated above, at 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart DiseaseDue To (b) with acute pulmonary edemaDue To (c) noneOTHER SIGNIFICANT CONDITIONS noneWas 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) Myron N. King, M. D.(Print or Type Name) Myron N. King, M.D.(Address) 221 Pleasant St. Date 11/27/67
 6 SHARO TIFILO WEST ROXBURY
 (Place of Burial or Cremation) (City or Town)
DATE OF BURIAL NOV. 28, 19677 NAME OF FUNERAL DIRECTOR ROBERT LevineADDRESS 1668 BEACON ST. BROOKLINEReceived and filed NOV 28 1967
John A. Clark
 (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 BLANCHE NESS
 (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 CARPENTER - RETIRED
 (Kind of work done during most of working life)
14 Industry or Business: SELF-EMPLOYED15 Social Security No. 029-05-068016 BIRTHPLACE (City) RUSSIA
 (State or country)17 NAME OF FATHER MOISHE ALOFF
 18 BIRTHPLACE OF FATHER (City) RUSSIA
 (State or country)
19 MAIDEN NAME OF MOTHER ASNER
 20 BIRTHPLACE OF MOTHER (City) RUSSIA
 (State or country)
21 Informant MRS. ROSE ABRAMSON(Address) 24 DOLPHIN AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip J. Vitagliano
 (Signature of Agent of Board of Health or other)

Dir. of Public Health 11/28/67
 (Official Designation) (Date of Issue of Permit)

 filed for burial permit
 th 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,
 sthenia, 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-
 uted to death but not
 related to the terminal
 disease condition given
 in (a).

H. LEBANON

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 28 67 PM



NON CLERK

1153

FORM R-301

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.

254

No. Bay View Nursing Home

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Isabel (Woodring) Zehringer

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)

20 Chester Ave.

Winthrop, Mass.

(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 November 28 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 1 53, to November 28 67.

I last saw her alive on November 28, 1967, death is said to have occurred on the date stated above, at 9:00a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bilateral bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

2 wks.

(b) Due To Fractured left hip & left humerus

7 wks.

(c) Due To Arteriosclerotic & hypertensive heart disease

12 yrs.

OTHER SIGNIFICANT CONDITIONS Pernicious anemia

15 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. 11-28 67

Winthrop, Mass.

6 Newton Cemetery Newton

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 30 1967

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word)
Female	White	MARRIED WIDOWED DIVORCED Widow UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

John Zehringer

(Husband's name in full)

12 AGE 97 Years 9 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: at home

15 Social Security No. 012-38-3896

16 BIRTHPLACE (City) Columbus Junction
(State or country) Iowa

17 NAME OF FATHER James Woodring

18 BIRTHPLACE OF FATHER (City) Pennsylvania
(State or country)

19 MAIDEN NAME OF MOTHER Sarah Roth

20 BIRTHPLACE OF MOTHER (City) Pennsylvania
(State or country)

21 Informant Victoria Snow

(Address) Epping New Hampshire

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vitagliano (h)

(Signature of Agent of Board of Health or other)

Dir. of Public Health 11/29/67

(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:

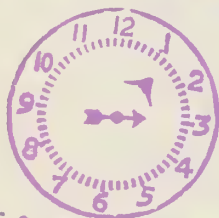
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(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.



OFFICE OF THE TOWN CLERK
 WINTHROP MASS

FORM R-301

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.

255

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 SUZANNE AUGEREAU (Delmouly)
 (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 SAGAMORE AVENUE

 SIX WINTHROP, MASSACHUSETTS
 (City or town and State)

Length of stay: In place of death... years... months... 3 days. In place of residence... 1 years... months... days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH NOV. 29 1967
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
 November 19, 1967, to NOV. 29, 1967
 I last saw her alive on November 29, 1967, death is said to
 have occurred on the date stated above, at 9:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia (terminal)

Due To (b) Cirrhosis of liver

Due To (c)

OTHER SIGNIFICANT CONDITIONS

arteriosclerosis

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) JOSEPH P. CAGGIANO

(Address) 174 Washington St. Date NOV. 29 1967

6 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 2, 1967

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed DEC 1 1967

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 (Give maiden name of wife in full)

(or) WIFE of Armand Augereau (Husband's name in full)

 12 AGE 69 Years 1 Months 18 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) Paris (State or country) France

17 NAME OF FATHER Theophile Delmouly

 18 BIRTHPLACE OF FATHER (City) France
 (State or country)

19 MAIDEN NAME OF MOTHER Irene Majouffet

 20 BIRTHPLACE OF MOTHER (City) France
 (State or country)

21 Informant Simone I. Carrozza

(Address) 20 Sagamore Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano

(Signature of Agent of Board of Health or other)

Director of Public Health 12/1/67

(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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DEC 1 '67 PM



CLERK

3.

FORM R-301

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,
apoplexy, 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 given
(d).

The Commonwealth of Massachusetts		Suffolk (County)		Winthrop, Mass. (City or Town)		Winthrop, Mass. (City or Town making this return)	
1 PLACE OF DEATH		Winthrop Community Hospital		No.		STANDARD CERTIFICATE OF DEATH	
2 FULL NAME		Isaac Liebert		(If deceased is a married, widowed or divorced woman, give also maiden name.)		Registered No. 256	
(a) Permanent Residence. No.		48 Shawmut Street, Revere, Mass.		St.		(If death occurred in a hospital or institution, give its NAME instead of street and number) PHYSICIAN — IMPORTANT	
Length of stay: In place of death		years 1 months 7 days		In place of residence		years 35 months 0 days	
MEDICAL CERTIFICATE OF DEATH				PERSONAL AND STATISTICAL PARTICULARS			
3 DATE OF DEATH		NOV. 30 1967		8 SEX		9 COLOR	
(Month) (Day) (Year)				MALE		WHITE	
4 I HEREBY CERTIFY, That I attended deceased from		JAN. 1965 to NOV. 30, 1967		10 SINGLE (write the word)		MARRIED	
I last saw him alive on		NOV. 30, 1967, death is said to		WIDOWED		DIVORCED	
have occurred on the date stated above, at		8:50 P.m.		UNKNOWN		WIDOWED	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE		Interval between onset and death		11 If married, widowed, or divorced		HUSBAND of	
(a) Cerebrovascular Occlusion		3 days		(or) WIFE of		CAROLINE (BRADFORD)	
(b) Cerebral Arteriosclerosis and		2 yrs.		(Give maiden name of wife in full)			
(c) Rt. Hemiplegia				12 AGE		79 Years Months Days	
OTHER SIGNIFICANT CONDITIONS		Arteriosclerotic Heart Disease and Congestive Failure		13 Usual Occupation		MEAT CUTTER RETIRED	
Was autopsy performed?		NO		14 Industry or Business		FOOD	
What test confirmed diagnosis?		CLINICAL		15 Social Security No.		011-01-3832	
5 Was disease or injury in any way related to occupation of deceased?		NO		16 BIRTHPLACE (City) (State or country)		LITHUANIA	
If so, specify		Charles Lieberman		17 NAME OF FATHER		BERNARD LIEBERT	
(Signature)		Charles Lieberman, M. D.		18 BIRTHPLACE OF FATHER (City) (State or country)		LITHUANIA	
(Print or Type Name)		Charles Lieberman		19 MAIDEN NAME OF MOTHER		CBL	
(Address)		WINTHROP, MASS. Date 11/30/1967		20 BIRTHPLACE OF MOTHER (City) (State or country)		LITHUANIA	
6 SHARON MEM. PK. SHARON MASS		Place of Burial or Cremation (City or Town)		21 Informant		ROBERTA COLLINS	
DATE OF BURIAL		DEC. 3 1967		(Address)		108 GRANDVIEW AVE WINTHROP	
7 NAME OF FUNERAL DIRECTOR		TORF FUNERAL SERV.		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:			
ADDRESS		1615 BEACON ST BROOKLINE		(Signature of Agent of Board of Health or other)		Philip G. Vitzthum	
Received and filed		DEC 1 1967		(Official Designation)		Dir. of Public Health	
A TRUE COPY ATTEST:		John A. Clark		(Date of Issue of Permit)		12/1/67	

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 1 '67 PM



OFFICE CLERK
WINTHROP MASS

REVIEW
NATHANIEL - 12-8-67

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
e, or compli-
which causedns, if any,
ave rise to
cause (a),
the under-
cause last.ions contrib-
death but not
the terminal
condition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
ificates.

50M-1-58-921876

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

WINTHROP

257

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. _____

No. Viking Nursing Home (If death occurred in a hospital or institution,
St. [give its NAME instead of street and number])2 FULL NAME Laura E. Broussard
(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. 30 Pauline St., St. _____
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death 2 years 2 months _____ days. In place of residence 40 years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 1, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
July, 1967, to Dec 1, 1967.I last saw her alive on Dec. 1, 1967, death is said to
have occurred on the date stated above, at 11:00 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer Right BreastINTERVAL
BETWEEN
ONSET AND
DEATH2 yrsDue To with metastasis
(b) _____Due To
(c) _____OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis Clinical. Surgical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____(Signed) Charles Liberman
CHARLES LIBERMAN, M. D.(Address) WINTHROP, MASS Date Dec. 1, 19676 St. Joseph's Boston, Mass
Place of Burial or Cremation (City or Town)DATE OF BURIAL December 4, 19677 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
Winthrop, Mass
ADDRESSReceived and filed DEC 4 1967 19John J. Clare
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)(or) WIFE of Charles Broussard
(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: Housewife
(Kind of work done during most of working life)14 Industry or Business: own home

15 Social Security No. _____

16 BIRTHPLACE (City) East Boston, Mass
(State or country)17 NAME OF FATHER William Lynch18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)19 MAIDEN NAME OF MOTHER Mary Smith20 BIRTHPLACE OF MOTHER (City) New York
(State or country)21 Informant Margar et Lynch
(Address) 119 Roland Road WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano
(Signature of Agent of Board of Health or other)Dir of Public Health 12/4/67
(Official Designation) (Date of Issue of Permit)

ENTRANCES

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.

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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

Filed for burial permit
by 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,
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
attributed to the terminal
cause condition given
(a).

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. ...

258

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 Elizabeth Doggett
(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. 805 East Broadway St. South Boston, Mass.
(City or town and State)

Length of stay: In place of death years months 1 days. In place of residence 85 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 6 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Apr. 20, 1967, to DEC 6 1967

I last saw her live on DEC 5 1967, death is said to
have occurred on the date stated above, at 5:53 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR THROMBOSIS
AND UREMIA

(b) ARTERIO-SCLEROTIC HEART DIS.
METABOLIC DISORDERS

(c) OTHER SIGNIFICANT CONDITIONS

OLD CVA CRT HEMIPLEGIA 13 mo.

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) Myron N. King M.D.

(Address) 22 Pleasant St. Date 12/6/67
WINTHROP MASS.

6 Fairview Cemetery, Boston, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 8 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. Keenell

ADDRESS 195 Mt. Auburn St., Watertown, Mass.

Received and filed DEC 7 1967

John H. Clare (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 85 Years 1 Months 7 Days If under 24 hours
Hours Minutes

13 Usual Occupation Registered Nurse
(Kind of work done during most of working life)

14 Industry or Business Boston City Hospital

15 Social Security No. 015-38-1439

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

17 NAME OF FATHER Frederick F. Doggett

18 BIRTHPLACE OF FATHER (City) Barnstable, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Mary C. DeWolf

20 BIRTHPLACE OF MOTHER (City) Cambridge, Mass.
(State or country)

21 Informant Arthur L. Doggett

(Address) 51 Adams Ave., Watertown, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip S. Vitagliano
(Signature of Agent of Board of Health or other)

Sir of Public Health 12/7/67
(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 7 '67 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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)

No.

Bay View Nursing Home

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Registered No. 259

PHYSICIAN — IMPORTANT

2 FULL NAME

Anastasios Panagiotopoulos

(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.

308 Bowdoin

St.

Winthrop

MASS.

(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 Dec 8, 1967
(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 1:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

(b) to natural causes

Due To (c) Winthrop Board of Health

OTHER
SIGNIFICANT
CONDITIONS

Charles Liberman

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 12/9/1967

6 Winthrop Cemetery Winthrop Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 11 1967

7 NAME OF FUNERAL DIRECTOR Paul K. Babalas

ADDRESS 336 Broadway Camb Mass

Received and filed DEC 11 1967

John A. Clark

(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 Sophie Papoulias
(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 Fruit Dealer
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 028-28-7410A

16 BIRTHPLACE (City) Greece
(State or country)

17 NAME OF FATHER Can not be learned

18 BIRTHPLACE OF FATHER (City) Greece
(State or country)

19 MAIDEN NAME OF MOTHER Can not be learned

20 BIRTHPLACE OF MOTHER (City) Greece
(State or country)

21 Informant Sophie Panagiotopoulos

(Address) 308 Bowdoin 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:Philip P. Magliaro
(Signature of Agent of Board of Health or other)Sir of Public Health 12/11/67
(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
more than one
cause for each
of (a), (b) and (c)This does not mean
mode of dying,
such as heart failure,
pneumonia, 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 process given
(a).Reported to Med. Examiner
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 face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, 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 11 '67 PM



OFFICE OF THE
WINTHROP

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
→ or compli-
which causeds, if any,
ve rise to
ause (a),
the under-
ause last.ons contrib-
→ eath but not
the terminal
dition givenChapter 137,
1954, requires
s to print or
cause or
death on
ificates.

50M-1-58-921876

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

David B. White

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

To be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 260

No. Viking Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Effie L. Briggs (Fales)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran, NO
if so specify WAR)

(a) Residence. No. 25 Corey St.

(Usual place of abode)

St. Charlestown

(If nonresident, give city or town and State)

Length of stay: In place of death 10 years months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 13 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

Jan. 1958, to Dec. 13, 1967

I last saw her alive on Dec. 13, 1967, death is said to

have occurred on the date stated above, at 10:30 P.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive and Arterio-
Sclerotic Heart Disease
(b) with congestive failure.5 yrs.
2 yrs.

Due To

(b) with congestive failure.

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Anemia, hypochromic

1 yr.

Was autopsy performed?

No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.

(Signed) CHARLES LIBERMAN

(Address) WINTHROP, MASS Date 12/13/1967

6 Glenwood Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 15 1967

7 NAME OF FUNERAL DIRECTOR David Fudge & Son Inc.

ADDRESS 100 Highland Ave. Somerville

Received and filed DEC 15 1967

John A. Clark

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Roland Briggs
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 5 Months 5 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. 010-22-5610

16 BIRTHPLACE (City) Everett
(State or country) Mass

17 NAME OF FATHER Isaac Fales

18 BIRTHPLACE OF FATHER (City) CNBL
(State or country) CNBL

19 MAIDEN NAME OF MOTHER Julia Stromach

20 BIRTHPLACE OF MOTHER (City) CNBL
(State or country) CNBL21 Informant Marion E. Poor
(Address) 19 Beechwood Rd. Sudbury, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vetrano Jr.
(Signature of Agent of Board of Health or other)Dir. of Public Health 12/5/67
(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 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

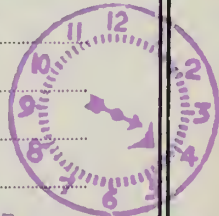
DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

DEC 15 8 1945



OFFICE OF THE
WINTER 1945

City notified 1-8-48

For burial permit
rd of Health
Agent.

CTIONS
OR
CERTIFICATE

OR TYPE
CAUSES
DEATH

ot enter
than one
for each
b) and (c)

es not mean
of dying,
near failure,
ic. It means
or compli-
which caused

as, if any,
ave rise to
ause (a),
the under-
ause last.

ions 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)

STANDARD CERTIFICATE OF DEATH

Registered No. 261

PLACE OF DEATH
SUFFOLK
(County)
WINTHROP
(City or Town)



Viking Nursing Home

((If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LEONA ELLIS (TRAVERS)
(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. 252 NORTH WEST 2ND ST. MIAMI FLA.
(Usual place of abode) (City or town and State)

Length of stay: In place of death years 4 months 4 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC 14 1967
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
JUL 9/11 1967, to DEC 14 1967

I last saw h.c. alive on DEC 12 1967, death is said to
have occurred on the date stated above, at 7:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION

INTERVAL
BETWEEN
ONSET AND
DEATH
20

Due To (b) ARTERIO-SCLEROTIC &
HYPERTENSIVE HEART DISEASE 2YR

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.
(Print or Type Name)

(Address) 211 Pleasant St. Date DEC 15 1967

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 14 1967

7 NAME OF FUNERAL DIRECTOR BISBEE & SONS

ADDRESS 349 LINCOLN AVE SAUGUS

Received and Med DEC 15 1967

John Allaire

(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 JOSEPH ELLIS

(Husband's name in full)

12 AGE 46 Years Months Days If under 24 hours

Hours Minutes

13 Usual Occupation ENTERTAINER

(Kind of work done during most of working life)

14 Industry or Business CIRCUS

15 Social Security No.

16 BIRTHPLACE (City) EAST BOSTON

(State or country) MASS

17 NAME OF FATHER JOSEPH TRAVERS

18 BIRTHPLACE OF FATHER (City) PROVINCETOWN

(State or country) MASS

19 MAIDEN NAME OF MOTHER MARY WHALEN

20 BIRTHPLACE OF MOTHER (City) CAPE BRITTON

(State or country) N.S.

21 Informant MRS JAMES HUSBAND

141 CENTRAL ST. SAUGUS MASS

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitaliano, Jr.

(Signature of Agent of Board of Health or other)

Director of Public Health 12/15/67

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

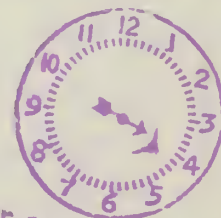
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 15 '67 PM



OFFICE OF THE TOWN CLERK
 WINTHROP, MASS.

File not filed 1-8-68

X+

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. 262

No. Viking Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Maria Rosatto (COGORNIO)

(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. 115 Linden St

St. East Boston

(City or town and State)

Length of stay: In place of death years 8 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 15 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 67 to Dec. 15 67

I last saw alive on Dec. 15 1967 death is said to

have occurred on the date stated above, at 1:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebro-Vascular Hemorrhage

Due To (b) Arterio Sclerosis

Due To (c) Geni

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) John P. Grogan, M. D.

(Print or Type Name)

(Address) 12-15-67

Date 12-15-67

6 Woodlawn Cemetery, Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL 12/18/67

1967

7 NAME OF DIRECTOR Raymond F. Cuttler

ADDRESS 773 Brandeis Rd

Received and filed DEC 15 1967

John A. Clark

(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 Lewis Rosatto

(Husband's name in full)

12 AGE 70 Years 4 Months 2 Days If under 24 hours

Hours Minutes

13 Usual Occupation Housewife

(Kind of work done during most of working life)

14 Industry or Business Housewife

15 Social Security No. NO

16 BIRTHPLACE (City) Falls

(State or country)

17 NAME OF FATHER ? - COGORNIO

18 BIRTHPLACE OF FATHER (City) Winthrop

(State or country)

19 MAIDEN NAME OF MOTHER

20 BIRTHPLACE OF MOTHER (City) Winthrop

(State or country)

21 Informant John Rosatto

(Address) 68 St Andrew Rd E13

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitashiano Jr.

(Signature of Agent of Board of Health or other)

Director of Public Health 12/15/67

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 15 '67 PM



OFFICE OF THE CLERK
WINTHROP

R-303

For burial permit
and 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.

100N-9-63-936348

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

Enroute to Winthrop Community Hospital

No.

St.

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

WINTHROP

(City or Town making this return)

Registered No. 263

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

2 FULL NAME GERALD COHEN
(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. 17 Hutchinson Street 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. 19 years. _____ months. _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 16, 1967
(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.)

Cranio-facial traumatic injury.
crushing injury of chest.
Fracture of femur and pelvis.

5 Accident, suicide, or homicide (specify) Accident
Date and hour of injury December 16, 1967

IF ACCIDENTAL, was injury causally related to the death? _____

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? Public highway
(Specify type of place)

Manner of
Injury Passenger in automobile
(How did injury occur?)

Nature of
Injury which collided with oil truck

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.

Michael A. Luongo, M.D.
(Print or Type Name)

(Address) Boston Date 12/17 1967

7 SHARON MEM PH. SHARON
Place of Burial or Cremation. Dec 18 (City or Town)

DATE OF BURIAL Dec 18 1967

8 NAME OF FUNERAL DIRECTOR TORI Funeral Service

ADDRESS 1615 BEACON ST BROOKLINE
DEC 18 1967

Received and filed John A. Clark 19. _____

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX MALE 10 COLOR WHITE 11 SINGLE (write the word)
MARRIED
WIDOWED SINGLE
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 19 Years. _____ Months. _____ Days
If under 24 hours
_____ Hours _____ Minutes

14 Usual Occupation: STUDENT
(Kind of work done during most of working life)

15 Industry or Business: STUDENT

16 Social Security No. 032-38-8345

17 BIRTHPLACE (City) WINTHROP MASS
(State or country)

18 NAME OF FATHER Robert S Cohen

19 BIRTHPLACE OF FATHER (City) Boston Mass
(State or country)

20 MAIDEN NAME OF MOTHER MILDRED LEVY

21 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

22 Informant Mr Robert Cohen
(Address) 17 Hutchinson St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano Jr.
(Signature of Agent of Board of Health or other)

Dir. of Public Health 12/18/67
(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 (gas bacillus), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection 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.)"

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

Kevin H. White WINTHROP

 To be filed for burial permit
 with Board of Health
 or its Agent.

Registered No.

264

No. Viking Nursing Home

 (If death occurred in a hospital or institution,
 give its NAME instead of street and number)

2 FULL NAME AGNES J. BROWN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

 (Was deceased a
 U. S. War Veteran,
 if so specify WAR)

No

(a) Residence. No. 73 Loring Road

St. Winthrop

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months 6 days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 18, 1967
(Month) (Day) (Year)
 4 I HEREBY CERTIFY, That I attended deceased from
 JAN., 1955, to Dec. 18, 1967
 I last saw her alive on Dec. 18, 1967, death is said to
 have occurred on the date stated above, at 1:30 P.M.

 INTERVAL
 BETWEEN
 ONSET AND
 DEATH

2 yrs

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

 (a) Generalized Arterio-
 sclerosis and
 (b) Cerebral arteriosclerosis

Due To

Due To (c)

OTHER SIGNIFICANT CONDITIONS First Right Kidney 3yrs.

 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 H. LIBERMAN M.D.
 (Address) WINTHROP, MASS Date 12-18-1967

6 Winthrop Cem. Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 21, 1967 19

7 NAME OF FUNERAL DIRECTOR Porcella Funeral Ser.

ADDRESS 876 Winthrop Ave. Revere

Received and filed DEC 20 1967 19

(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 Patrick J. Brown

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 0 Months 6 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) Gloucester
 (State or country) Mass.

17 NAME OF FATHER William Malloy

 18 BIRTHPLACE OF FATHER (City) Nova Scotia
 (State or country)

19 MAIDEN NAME OF MOTHER Katherine Power

 20 BIRTHPLACE OF MOTHER (City) Boston
 (State or country) Mass.

 21 Informant Ruth E. Collins
 (Address) 73 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:

Philip G. Vitagliano (31)

(Signature of Agent of Board of Health or other)

 Sir of Public Health
 (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 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

DEC 20 '67 PM



CE OF THE TOWN CLERK
WINTHROP, MASS.

VM

FORM R-301

filed for burial permit
h 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,
such as heart failure,
pneumonia, 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-
ing to death but not
ated to the terminal
cause condition given
(a).

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. 265

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 14 Hermon St.

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Hilary T. Minton
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, WW #1
if so specify WAR)

(a) Permanent Residence. No. 15 Read St., St. (City or town and State)

Length of stay: In place of death, years, months, days. In place of residence 45 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 18, 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from
MAR 28, 1967, to DEC 18, 1967,
I last saw him alive on DEC 11, 1967, death is said to
have occurred on the date stated above, at 12:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION 10 MIN

Due To (b) ARTERIO-SCLEROTIC HEART DISEASE 2 YRS

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? S.M.I. etc

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron H. Keeney, M. D.

(Print or Type Name)
MYRON H. KEENEY, M.D.

(Address) WINTHROP, MASS. Date: DEC 19, 1967

6 St. Joseph's Boston, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 21, 1967

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed DEC 20 1967

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
HUSBAND of Anna A. Flynn
(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 Retired Ass't Supt.
(Kind of work done during most of working life)

14 Industry or Business: U.S. Gen. Ser. Adm.

15 Social Security No. 030-09-7353 A

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER Richard Minton

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Sarah McDonald

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant Anna Minton

(Address) 15 Read St.,

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Dir. of Public Health 12/20/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....4-26-18

DATE OF DISCHARGE.....1-8-19

RANK, RATING.....Pvt

ORGANIZATION AND OUTFIT.....Army

SERVICE NUMBER.....1 691 377

.....

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 Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, 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 20 '67 PM



PRICE OF THE TOWN CLERK
WINTHROP, MASS.

MARGIN RESERVED FOR BINDING
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-5-64-938000

PLACE OF DEATH

Norfolk

(County)

Foxborough

(City or Town)

Foxborough State Hospital

No. _____ St. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number)

Flossie Moore

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

80 Reed

(a) Permanent Residence. No. _____

Winthrop, Mass.

23 11 17

Undetermined

(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 19 1967
(Month) (Day) (Year)

I last saw _____ alive on December 18 1967, death is said to have occurred on the date stated above, at 1:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Bronchopneumonia

(a) _____ 10 days

Due To

(b) _____

Due To

(c) _____

OTHER SIGNIFICANT CONDITIONS

No

Was autopsy performed? Clin.-lab. findings

What test confirmed diagnosis? No

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

Michulan Bazan

(Signature) _____, M. D.

Foxborough, Mass. Dec. 19 67

(Address) _____ Date _____ 19 _____

Winthrop Cemetery Winthrop, Mass.

6 Place of Burial or Cremation _____ (City or Town) _____

DATE OF BURIAL December 21 1967

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS 160 Winthrop St., Winthrop, Mass.

Received and filed

January 2, 1968

(Registrar of City or Town where deceased resided)

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. 266

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

Years _____ Months _____ Days _____

If under 24 hours

Hours _____ Minutes _____

13 Usual

Occupation: Librarian

(Kind of work done during most of working life)

14 Industry

or Business: _____

15 Social Security No. _____

16 BIRTHPLACE (City) _____ (State or country) Massachusetts

17 NAME OF FATHER

Eli Moore

18 BIRTHPLACE OF FATHER (City)

(State or country)

Cannot be learned

Newfoundland

19 MAIDEN NAME OF MOTHER

Cassie J. Morrow

20 BIRTHPLACE OF MOTHER (City)

(State or country)

Cannot be learned

Prince Edward Island

21 Informant

Foxborough State Hospital Records

Foxborough, Mass.

(Address) _____

A TRUE COPY

Mildred J. Shannon - Agent Board of Health

(Registrar of City or Town where death occurred)

DATE FILED

12-19-67

19 _____

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

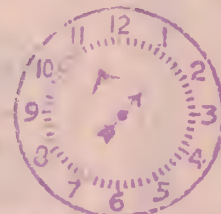
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

JAN -2 '68 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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. 267

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 297 Bowdoin Street (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

filed for burial permit
th Board of Health
or its Agent.INSTRUCTIONS
FOR
DIGITAL CERTIFICATE2 FULL NAME Dorothy Carmichael
(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. 297 Bowdoin St. Winthrop, Mass.
(City or town and State)PRINT OR TYPE
USE OR CAUSES
OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)This does not mean
mode of dying,
such as heart failure,
hemiplegia, etc. It means
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
(a).

Length of stay: In place of death 17 years.....months.....days. In place of residence 17 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 20 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Jan 1, 1964 to Dec 20, 1967
I last saw him alive on Dec 17, 1967, death is said to
have occurred on the date stated above, at 10:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Occlusion 1 day

(b) Due To Hypertensive Arterio- 4 yrs.

(c) Due To Sclerotic Heart Disease

OTHER SIGNIFICANT CONDITIONS Pernicious Anemia 6 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 12/20/1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 22, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed DEC 21 1967

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 (Give maiden name of wife in full)

(or) WIFE of Reginald Carmichael
(Husband's name in full)

12 AGE 72 Years 9 Months 24 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. 020-10-4057

16 BIRTHPLACE (City) Warren
(State or country) Massachusetts

17 NAME OF FATHER Patrick O'Donnell

18 BIRTHPLACE OF FATHER (City) North Hampton
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Mathilde Guertin

20 BIRTHPLACE OF MOTHER (City) Spencer
(State or country) Massachusetts

21 Informant Mrs. Arthur Didham

(Address) 1140 Main St. Reading, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was furnished with me BEFORE the burial or transit permit was issued:Philip G. Vitoagliano
(Signature of Agent of Board of Health or other)Director of Public Health 12/21/67
(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.

21 '67 PM



OFFICE OF
WINT

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.

268

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 Gallant, Helena M. (LEAVITT)
 (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 Road
 St. Winthrop, Mass.
 (City or town and State)

Length of stay: In place of death.....years.....1 months.....7 days. In place of residence.....2 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 23 1967
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
 Nov-17, 1967, to DEC 23, 1967

I last saw her alive on DEC 23, 1967, death is said to
 have occurred on the date stated above, at 1:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE PULMONARY EMBOLUS
 INTERVAL BETWEEN ONSET AND DEATH 5 MIN

(b) Due To CARCINOMA OF COLON 2 MO.

(c) Due To

OTHER SIGNIFICANT CONDITIONS ARTERIO-SCLEROTIC HEART DISEASE 1 YR.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & X-RAY

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 DEC 23, 1967
 WINTHROP, MASS.

6 CALVARY SOUTH PORTLAND ME.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 27, 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP, MASS.

Received and filed DEC 27, 1967

John A. Clark (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN DIVORCED

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of HENRY GALLANT (Husband's name in full)

12 AGE 77 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation CLERK (Kind of work done during most of working life)

14 Industry or Business DEPARTMENT STORES

15 Social Security No. 004-40-6540 A

16 BIRTHPLACE (City) PORTLAND (State or country) MAINE

17 NAME OF FATHER CHARLES LEAVITT

18 BIRTHPLACE OF FATHER (City) BRUNSWICK (State or country) MAINE

19 MAIDEN NAME OF MOTHER NELLIE KAVANAUGH

20 BIRTHPLACE OF MOTHER (City) MAINE (State or country)

21 Informant MRS. DORIS PIECEWICZ

(Address) 122 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:

Philip G. Vitagliano (M.D.)
 (Signature of Agent of Board of Health or other)
 Director of Public Health 12-27-67
 (Official Designation) (Date of Issue of Permit)

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,
 as heart failure,
 pneumonia, etc. It means
 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
 (a).

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
ard of Health
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
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

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Cliff House Nursing Home(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Laura Louise White (Keife)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence, No. 12 Sewall Avenue
(Usual place of abode)St. Winthrop, Mass.
(City or town and State)Length of stay: In place of death, 1 years 9 months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 23, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JAN., 1960 to Dec. 23, 1967I last saw h.e. alive on Dec. 22, 1967, death is said to
have occurred on the date stated above, at 9:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Phenomena(b) and Cerebrovascular Coarctation(c) with left hemiparesisOTHER SIGNIFICANT CONDITIONS
Cerebral Arteriosclerosis
HypertensionWas autopsy performed? NoWhat 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 MD
(Print or Type Name)(Address) WINTHROP, MASS. Date 12/23/19676 Cambridge Cemetery, Cambridge
Place of Burial or Cremation (City or Town)DATE OF BURIAL December 28, 19677 NAME OF FUNERAL DIRECTOR Alfred B. MarshADDRESS 174 Winthrop St. WinthropReceived and filed DEC 28 1967

(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 DEATHRegistered No. 269(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
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Fredrick Burnham White
(Give maiden name of wife in full)(or) WIFE of Fredrick Burnham White
(Husband's name in full)12 AGE 87 Years 6 Months 21 Days If under 24 hours
Hours Minutes13 Usual Occupation housework
(Kind of work done during most of working life)14 Industry or Business own home15 Social Security No. none16 BIRTHPLACE (City) Souris
(State or country) Prince Edward Island17 NAME OF FATHER John Keife18 BIRTHPLACE OF FATHER (City) Prince Edward Island
(State or country)19 MAIDEN NAME OF MOTHER Louise MacCallun20 BIRTHPLACE OF MOTHER (City) Prince Edward Island
(State or country)21 Informant Orrin F. B. White, Jr.(Address) 114 Fenway, Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip H. Vitagliano (M.D.)
(Signature of Agent of Board of Health or other)Director of Public Health 12-28-67
(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.

mx

FORM R-301

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. 230

No. Winthrop Community 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) NO2 FULL NAME Palais, Ethel (Ziegler)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 53 Trident Ave, Winthrop

St. (City or town and State)

Length of stay: In place of death years months 1 days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec 24 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JAN 1952 to Dec 24, 1967I last saw her alive on Dec 24, 1967, death is said to
have occurred on the date stated above, at 11:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

Due To (b) Arteriosclerotic Heart

Due To (c) Disease

INTERVAL
BETWEEN
ONSET AND
DEATH1 day
1 yrOTHER SIGNIFICANT CONDITIONS Diabetes Mellitus 8 yrs
RHEUMATOID ARTHRITIS 10 yrsWas autopsy performed? Clinical
What test confirmed diagnosis5 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 12/24/1967

6 TIFERETH ISRAEL OF WINTHROP, EVERETT
(City or Town)

DATE OF BURIAL DECEMBER 26 19 67

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERV., INC.

ADDRESS 1615 BEACON ST., BROOKLINE

Received and filed DEC 26 1967

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 (Give maiden name of wife in full)

(or) WIFE of WILLIAM PALAIS
(Husband's name in full)12 AGE 82 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) RUSSIA
(State or country)

17 NAME OF FATHER BENJAMIN ZIEGLER

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER NELLIE (PALAIS)

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

21 Informant MRS. ALICE PHILLIPS (SISTER)

(Address) 99 PURITAN LANE, SWAMPSCOTT

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Philip G. Vitagliano, Jr.
(Signature of Agent of Board of Health or other)Director of Public Health 12/26/67
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 26 '67 PM



TOWN CLERK

MASS.

The Commonwealth of Massachusetts

Suffolk

(County)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 271

No. 31 Undine Avenue

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Hugh McKenzie Hewitt

(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 Undine Avenue St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 1 years months days. In place of residence 1 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 25 1967
(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 11:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due To natural causes, presumably

(c) Due To acute coronary occlusion on basis of history.

OTHER SIGNIFICANT CONDITIONS With History of Health Charles Liberman and

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 12/28/ 1967

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 29, 1967

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed DEC 29 1967

A TRUE COPY ATTEST:

(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 Marion Virginia Sanborn (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 61 years 2 Months 8 Days If under 24 hours Hours Minutes

13 Usual Occupation salesman (Kind of work done during most of working life)

14 Industry or Business: Frozen Food Co.

15 Social Security No. 029-12-4100

16 BIRTHPLACE (City) Winthrop (State or country) Massachusetts

17 NAME OF FATHER Hugh McKenzie Hewitt

18 BIRTHPLACE OF FATHER (City) Green Harbor (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Minnie Kean

20 BIRTHPLACE OF MOTHER (City) Jordan Bay (State or country) Nova Scotia

21 Informant Mrs. Leonard R. Sundberg

(Address) 20 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:

Philip G. Vitagliano (MCK)

(Signature of Agent of Board of Health or other)

Director of Public Health 12-29-67

(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.

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. 272

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 ESTHER BINDER
(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. 16 Sixth St Chelsea
(City or town and State)

Length of stay: In place of death years 11 months days. In place of residence 60 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 26 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12-31, 1966, to 12-26, 1967.

I last saw him alive on 12-23, 1967, 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 arteriosclerosis

(b) Due To diabetes

OTHER SIGNIFICANT CONDITIONS uremia

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) 747 Shirley St W. H. H. Date 12-26 1967

6 KNIGHTS of Liberty Woburn

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 28 1967

7 NAME OF FUNERAL DIRECTOR TORI Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed DEC 28 1967

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEM 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 JOSEPH BINDER (Husband's name in full)

12 AGE 88 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 ABRAHAM KALLMAN

18 BIRTHPLACE OF FATHER (City) RUSSIA (State or country)

19 MAIDEN NAME OF MOTHER BRANDYL

20 BIRTHPLACE OF MOTHER (City) RUSSIA (State or country)

21 Informant HARRY BINDER

(Address) 7 Stonehill Rd Stoneham

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (nick)

(Signature of Agent of Board of Health or other)

Director of Public Health 12-27-67 (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.

FORM R-301

The Commonwealth of Massachusetts

SUFFOLK

(County)

WINTHROP

(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. 273

No. WINTHROP COMMUNITY HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY R. MOONEY (NEE MARY R. McCULLOCH)

(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. 465 BOULEVARD

St. REVERE, MASSACHUSETTS
(City or town and State)

Length of stay: In place of death.....years.....months.....days. 16 days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 26 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12/11/67 19 to 12/26/67 19

I last saw her alive on 12/26/67 19, death is said to have occurred on the date stated above, at 7:45 pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiovascular collapse hours

(b) Carcinomatosis days

(c) Carcinoma of bowel months

INTERVAL
BETWEEN
ONSET AND
DEATHOTHER
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) Dr. Nicholas A. Casaburi M. D.

(Address) 81 Beale St. Revere 12/26 1967
(Print or Type Name)6 Oak Grove Meaford
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 30 December 1967 19

7 NAME OF FUNERAL DIRECTOR John E. Shea

ADDRESS Dorchester, Mass.

Received and filed DEC 29 1967 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Wiaow

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Joseph M. Mooney (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. 030 20 7800 T

16 BIRTHPLACE (City) Boston Mass. (State or country)

17 NAME OF FATHER George McCulloch

18 BIRTHPLACE OF FATHER (City) Boston Mass. (State or country)

19 MAIDEN NAME OF MOTHER Kathleen Dalton

20 BIRTHPLACE OF MOTHER (City) ? Canada (State or country)

21 Informant Joseph P. Mooney (Address) 465 Boulevard Revere, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip D. Vitagliano (M.D.) (Signature of Agent of Board of Health or other)

Director of Public Health 12-29-67 (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.



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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. 274

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 FRANCES L SULLIVAN (GORMAN)

(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 LOWELL RD St. WINTHROP, MASS

(City or town and State)

Length of stay: In place of death 5 years months days. In place of residence 5 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC. 26 1967

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from Oct. 1, 1960, to DEC. 26, 1967

I last saw her live on DEC. 23, 1967 death is said to have occurred on the date stated above, at 3:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerosis & Hypertensive Heart Disease 7 YRS

Due To (b) Generalized Arteriosclerosis & YRS

Due To (c) —

OTHER SIGNIFICANT CONDITIONS Cerebral Arterio-sclerosis 4 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. Traubstein Jr. M. D.

(Address) 73 Bartlett Rd. Wintthrop, Mass. Date 12/26/67

6 HOLY CROSS MALDEN

Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 29 1967

7 NAME OF FUNERAL DIRECTOR MAURICE W MIRBY

ADDRESS WINTHROP

Received and filed DEC 29 1967

(Registrar)

A TRUE COPY ATTEST:

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

(or) WIFE of PHILIP E SULLIVAN (Give maiden name of wife in full)

(Husband's name in full)

12 AGE 79 Years Months Days If under 24 hours

13 Usual Occupation CLEERLY (Kind of work done during most of working life)

14 Industry or Business U.S. VET ADM.

15 Social Security No.

16 BIRTHPLACE (City) EAST BOSTON (State or country) MASS

17 NAME OF FATHER WILLIAM P GORMAN

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER CATHERINE SHEA

20 BIRTHPLACE OF MOTHER (City) BOSTON (State or country)

21 Informant WILLIAM P GORMAN

(Address) 31 LOWELL RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Vitagliano (M.D.)

(Signature of Agent of Board of Health or other)

Director of Public Health 12-29-67

(Official Designation) (Date of Issue of Permit)

filed for burial permit
th 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,
hemiplegia, etc. It means
disease, or compli-
cations which caused
th.

Conditions, if any,
which gave rise to
above cause (a),
affecting the under-
lying cause last.

Conditions contrib-
uting to death but not
related to the terminal
case condition given
(a).

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

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,
pneumonia, 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
(a).

1 PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

No. WINTHROP COMMUNITY HOSPITAL

Registered No. 275
(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JENNIE (ALOSA) FEDERICO

(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 Trenton Street, East Boston, Mass.

(City or town and State)

Length of stay: In place of death years 1 months 10 days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DECEMBER 28, 1967

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/11/67, 1967, to Dec 28, 1967

I last saw he alive on 12/28, 1967 death is said to have occurred on the date stated above, at 12:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic papillary

(b) Adenocarcinoma

(c) Splenic nodules & metastatic

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus

INTERVAL
BETWEEN
ONSET AND
DEATH

9/11/67

Sept 67

Was autopsy performed? no

What test confirmed diagnosis? Splenic biopsy & histology

5 Was disease or injury in any way related to occupation of deceased?

If so, specify no

(Signature) D. L. PATTE, M. D.

(Print or Type Name)

(Address) 17A Bennington St. Date 12/28/67

6 St Michael's Roslindale

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 2 1968

7 NAME OF FUNERAL DIRECTOR Vincent J. Mazzarella

ADDRESS 971 Saratoga St. E.B.

Received and filed

DEC 29 1967

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)

STANDARD

CERTIFICATE OF DEATH

Registered No. 275

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 JENNIE (ALOSA) FEDERICO

(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 Trenton Street, East Boston, Mass.

(City or town and State)

Length of stay: In place of death years 1 months 10 days. In place of residence 25 years months days.

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 Federico (Husband's name in full)

12 AGE 72 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. 001-10-0806A

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Pasquale Alosa

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Laudari Luigina

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Umberto Alosa

(Address) 26 Thurston St. E.B.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Philip G. Pataglione (not)
(Signature of Agent of Board of Health or other)

Director of Public Health
(Official Designation)

12-29-67
(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.

FORM R-301

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 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).

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.

276

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 Anthony M. Cianci
(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. 111 Neptune Road St. East Boston, Mass.
(City or town and State)

Length of stay: In place of death 5 years 5 months 36 days. In place of residence 36 years 5 months 36 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec 30 - 1967
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan 1966 to Dec 30, 1967

I last saw him alive on Dec 29, 1967 death is said to
have occurred on the date stated above, at 240 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary artery heart disease 1 yr.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSParkinson's DiseaseINTERVAL
BETWEEN
ONSET AND
DEATH6 yrs.Was autopsy performed? NoWhat test confirmed diagnosis? St. Min. (a)

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signature) Charles Meloni, M. D.

CHARLES MELONI
(Print or Type Name)

(Address) 45 Bay State St. Boston Date 12-30-67

Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 2nd, 1968

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed January 2, 1968

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 Margaret M. Loschi
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

12 AGE 76 Years 5 Months 17 Days If under 24 hours
Hours. Minutes

13 Usual Occupation Salesman
(Kind of work done during most of working life)

14 Industry or Business: Clothing

15 Social Security No. 022-01-2453

16 BIRTHPLACE (City) East Weymouth Mass.
(State or country)

17 NAME OF FATHER Frank Cianci

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Rachela Truda

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mrs. Margaret Cianci-wife

(Address) 111 Neptune 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:

Philip G. Vitagliano
(Signature of Agent of Board of Health or other)

Director of Public Health 12/68
(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.



OFFICE OF
WINTER

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

PLACE OF DEATH

MIDDLESEX

NEWTON

(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

NEWTON

(City or Town making this return)

Registered No. 647-67

No. 21 Lindbergh Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Florence M. O'Hara (Monahan) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, WW I if so specify WAR)

(a) Residence. No. 21 Lindbergh Avenue Newton, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 15 years, months, days. In place of residence 15 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 19 1967
(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
with Hypertension & Coronary Sclerosis
Found Dead in Bed

5 Accident, suicide, or homicide (specify) No
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) PeterAngelo, M. D.
820 Main Street
Waltham
(Address) Dec. 19, 1967

7 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
December 23, 1967
DATE OF BURIAL

8 NAME OF FUNERAL DIRECTOR Arthur J. O. Maley
ADDRESS Winthrop, Mass.

Received and filed January 8, 1968

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Patrick O'Hara (or) WIFE of (Husband's name in full)

13 AGE 74 Years 3 Months - 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. 014 - 22 - 3122A

17 BIRTHPLACE (City) Boston (State or country) Mass.

18 NAME OF FATHER John B. Monahan

19 BIRTHPLACE OF FATHER (City) Cannot be Learned (State or country) Ireland

20 MAIDEN NAME OF MOTHER Catherine Kelley

21 BIRTHPLACE OF MOTHER (City) Cannot be Learned (State or country) Ireland

22 Informant Patrick O'Hara Husband (Address)

21 Lindbergh Ave., West Newton, Mass.

A TRUE COPY

ATTEST: Joseph H. Kurlm (Registrar of City or Town where death occurred)

DATE FILED December 27, 1967

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE April 3, 1918

DATE OF DISCHARGE July 13, 1919

RANK, RATING Yeoman 1st Class

ORGANIZATION AND OUTFIT U. S. Navy

SERVICE NUMBER 1-443-494

JUN - 8 58 AM



OFFICE OF THE JUDGE ADVOCATE
WINTHROP, MASS

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.)

100W-5-61-938000

The Commonwealth of Massachusetts		Danvers	
KEVIN H. WHITE SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS		(City or Town making this return)	
Essex (County)		Danvers (City or Town)	
Danvers State Hospital No.		Registered No. 278	
1 PLACE OF DEATH		(If death occurred in a hospital or institution, St. give its NAME instead of street and number)	
2 FULL NAME Fannie Katz (Fannie Goldstein) (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. 80 Crest Avenue		St. Winthrop, Mass. (City or town and State)	
Length of stay: In place of death.....years..... 4 months..... 24 days. In place of residence.....years.....months.....days.			
MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH December 22, 1967 (Month) (Day) (Year)		8 SEX female	
4 I HEREBY CERTIFY , That I attended deceased from July 28, 1967 to December 22, 1967 . I last saw him alive on December 22, 1967 , death is said to have occurred on the date stated above, at 2:45 pm .		9 COLOR white	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral pneumonia		10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN widowed	
Due To Arteriosclerotic heart disease yrs.		11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Abraham F. Katz (or) WIFE of (Husband's name in full)	
Due To Generalized arteriosclerosis yrs.		12 AGE 78 Years 10 Months 23 Days If under 24 hoursHours.....Minutes	
OTHER SIGNIFICANT CONDITIONS		13 Usual Occupation: Housewife (Kind of work done during most of working life)	
Was autopsy performed? No What test confirmed diagnosis? Clinical & Laboratory		14 Industry or Business:	
5 Was disease or injury in any way related to occupation of deceased? If so, specify		15 Social Security No. 028-01-9734	
(Signature) Willard M. Hausman , M. D.		16 BIRTHPLACE (City) (State or country) Russia	
(Address) Hathorne, Mass. Date 12-22-67		17 NAME OF FATHER Samuel Goldstein	
6 Tiferoth Israel Cemetery Everett Place of Burial or Cremation (City or Town)		18 BIRTHPLACE OF FATHER (City) (State or country) Russia	
DATE OF BURIAL December 23, 1967		19 MAIDEN NAME OF MOTHER Etta Brenze	
7 NAME OF FUNERAL DIRECTOR Levine Funeral Chapel		20 BIRTHPLACE OF MOTHER (City) (State or country) Russia	
ADDRESS Brookline, Mass.		21 Informant Helen A. Ziolkowski (Address) Danvers, Mass.	
Received and filed John A. Clay 368 (Registrar of City or Town where deceased resided)		A TRUE COPY ATTEST: Daniel J. Toomey (Registrar of City or Town where death occurred)	
DATE FILED December 29, 1967			

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

JAN - 8 '68 AM



OFFICE OF THE TOWN CLERK
WINTHROP, MASS.

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

Middlesex

(County)

Tewksbury, Mass.

(City or Town)

TEWKSBURY HOSPITAL

No.

The Commonwealth of Massachusetts

279

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

TEWKSBURY HOSPITAL

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 231

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)2 FULL NAME Nellie M. Nelsson
(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. 152 Pleasant St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death, 0 years, 0 months, 21 days. In place of residence, 0 years, 0 months, 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 12, 1967
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov. 21, 1967 to Dec. 12, 1967
I last saw him alive on Dec. 11, 1967 death is said to
have occurred on the date stated above, at 6:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Accident 15 Hrs.(b) Gen. & Cerebral
Arteriosclerosis Yrs.(c) -----OTHER SIGNIFICANT CONDITIONS Gouty Arthritis
Paget's Dis. of SkullWas autopsy performed? No
What test confirmed diagnosis? Clinical & X-Ray5 Was disease or injury in any way related to occupation of deceased? No
If so, specify -----(Signed) Lois B. Crowell, M. D.(Address) TEWKSBURY HOSPITAL Date 12-12-676 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)DATE OF BURIAL December 14, 19677 NAME OF FUNERAL DIRECTOR Howard S. ReynoldADDRESS 150 Winthrop St., WinthropReceived and filed JAN - 9 1968 1968

(Registrar of City or Town where deceased resided)

INTERVAL
BETWEEN
ONSET AND
DEATH
15
Hrs.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed11 If married, widowed, or divorced
HUSBAND of Nels R. Nelsson (Give maiden name of wife in full)
(or) WIFE of Nels R. Nelsson (Husband's name in full)12 76 1 11
AGE Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most working life)14 Industry or Business: At Home15 Social Security No. 019-28-5065 JI16 BIRTHPLACE (City) Winthrop
(State or country) Mass.17 NAME OF FATHER Eugene Lewis18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country) Maine19 MAIDEN NAME OF MOTHER Jessie P. Spears20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country) Maine21 Informant (Address) Hospital Records

A TRUE COPY

ATTEST: [Signature] Supt.DATE FILED 12-12-67 1968

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

JAN - 9 '68 AM



OFFICE OF THE JUVENILE CLERK
WINTHROP, MASS

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. See reverse side for affidavit.

10M-12-61-939354

PLACE OF DEATH

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DEPOSITION

WRITE LEGIBLY WITH DURABLE BLACK INK

The Commonwealth of Massachusetts }
County of Suffolk } ss.:

The undersigned, being duly sworn, depose and say that the record relating to the death of Edward Gershman in the city of Revere,
(Give name of decedent exactly as recorded on the original record) (City or town) (Name of city or town)
does not fully and correctly state all the facts relating to said death, and that the true statement of facts omitted or incorrectly stated in said record has been supplied by her on the
(Him or her)
form of certificate on the other side of this blank.

SIGNATURE

RESIDENCE
(City or town, street and number, if any)

Relation to decedent,
if any

(s) Bella Gershman

207 Revere St., Winthrop

Wife

FURTHER, The written evidence submitted to substantiate the affidavit was:
Cert. of residence from town Clerk, Winthrop

Date, Sept. 4, 1968

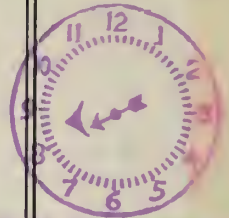
Then personally appeared before me the person whose signature appear above and made oath that the statements subscribed to by her are true.

Name (s) Joseph F. McChristal

Official designation City Clerk

(City or town clerk or assistant clerk)

SEP - 6 '68 AM



MARGIN RESERVED FOR BINDING

Charles S. Strasser

DECREE RE DEATH - All papers filed in folder
under DEATH CARDS -

