

DEPARTMENT OF HEALTH OF THE CITY OF BROOKLYN.

3725

CERTIFICATE OF DEATH.

-Full Name* Elizabeth Sheehan

-Age 29 years — months — days.

-Sex ~~Male~~, Female.* 4-White, ~~Colored~~.*

-~~Single, Married, Widow, Widower~~*

-Birthplace Brooklyn 7-Occupation Housewife

-If of foreign birth, how long in U. S. — years. 9-How long resident in City Life years.

-Father's birthplace* Ire 11-Mother's birthplace* Ire

-Place of Death,* No. 158 Duquesne St Brooklyn, Ward 12

-Number of families in house 3 14-On what floor 3



I HEREBY CERTIFY that I attended the deceased from March 1st 1898, to March 6th 1898
 that I last saw her alive on the 6th day of March 1898; that she died on the
6th day of March 1898, about 3-45 o'clock ~~A~~ or P. M., and that the following was the

-Cause of Death,*
 I. Appendicitis
 II. Anthrax

Time from attack till death,


This Certificate delivered to J. J. Hart at 3 P. M., March 8th 1898.
 Signed by J. J. Hogan M. D. No. 191 Nassau St Street or Avenue —
 Medical Attendant. Address.

* See other side for explanations and directions.

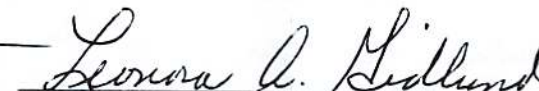
NEW YORK CITY DEPARTMENT OF RECORDS AND INFORMATION SERVICES
MUNICIPAL ARCHIVES
31 Chambers Street
New York, N.Y. 10007

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In issuing this copy of the record, the Department of Records and Information Services does not certify to the truth of the statements made thereon, as no inquiry to the facts has been provided by law.



Brian G. Andersson
Commissioner, Department of Records



Leonora A. Gidlund
Director, Municipal Archives

3725

17—Place of Burial Stoby Cross Cemetery.
18—Date of Burial March 9th 1898 In case of contagious diseases A. M. or P. M.
19—Undertaker Geo. L. Stani Place of Business 1196 Court St

*Write FAMILY NAME plainly and exactly. If the deceased was a child *not named*, state the names of both parents.
3, 4, 5, 15—Draw a line through the *words not required* on these lines.
6, 10, 11—Insert name of State or County.

12—If in a *Public Institution* please state its name and erase line 13.

16—I. Name the *Organic*. Principal, or most influential Disease or Injury. If an autopsy was made please so state.
II. Name any complication, remote cause, important event (as Operation, in Surgical Cases,) or the manner of Dying (Asphyxia, As-
thenta, Syncope, etc.) or prominent symptoms (as Convulsions, Dropsy, Jaundice, Paralysis, etc.) If the disease was Puerperal in origin, this
should be stated.

CONTAGIOUS DISEASES—Small Pox, Scarlet Fever, Diphtheria, Croup, Measles, Yellow Fever, Cholera.
Note to Undertakers—Physicians are responsible for the correctness of all facts inserted upon the face of this certificate; therefore no
changes or additions made by undertakers or others can be accepted.

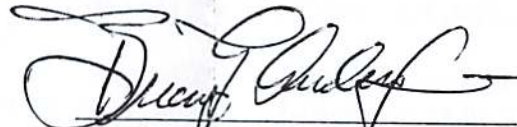
The law requires that the remains of those dying from a contagious disease shall be immediately disinfected, placed in a tightly sealed
coffin, and that the interment shall take place within 24 hours after death, and be strictly private; and that the remains be conveyed in a hearse—
the use of carriages or wagons for this purpose not being permitted. Undertakers and all other persons having charge of the remains of deceased
persons, are responsible for any violation of these rules.

Office for Burial Permits, 38-40 Clinton Street.
Hours from 9 to 5. Saturdays 9 to 3. Sundays and Holidays, 9 to 12.

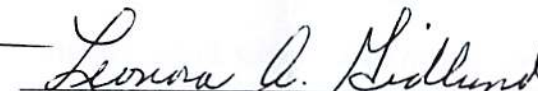
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