

[Form 85.]

DEPARTMENT OF HEALTH OF THE CITY OF BROOKLYN.

CERTIFICATE OF DEATH.

19664

1—Full Name*

James Freeman

2—Age

28 years — months — days.

3—Sex, Male, Female.*

4—White, Colored.*

5—Single, Married, Widow, Widower.*

6—Birthplace

U. S.

7—Occupation

Salesman

8—If of foreign birth, how long in U. S.

28 years.

9—How long resident in City

1 year.

10—Father's birthplace*

U. S.

11—Mother's birthplace*

U. S.

12—Place of Death,* No.

Norwegian Hospital

Brooklyn, Ward

8

13—Number of families in house

14—On what floor

15—I HEREBY CERTIFY that I attended the deceased from

November 3, 1896, to November 4, 1896

that I last saw him alive on the

4th

day of

November 1896; that he died on the

4th

day of

November 1896, about 2:30 o'clock A. M. or P. M.; and that the following was the

16—Cause of Death,*

I. *Suppurative appendicitis, Perforation*
II. *Operation, Exhaustion*

Time from attack till death,

4 days

This Certificate delivered to

E. J. Connor

at

7:30 P. M., November 4, 1896.

Signed by

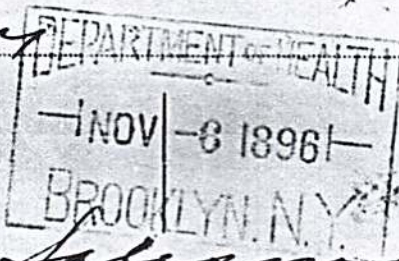
Sewell Matheson M. D.
Medical Attendant.

No.

Norwegian Hospital

Street or Avenue
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

This exact copy of a _____ certificate should not be accepted unless the raised seal of The Department of Records and Information Services is affixed thereon. The reproduction or alteration of this transcript is prohibited by Section 3.21 of the New York City Health Code.

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

17—Place of Burial Holy Cross Cemetery.

18—Date of Burial Nov 16th

In case of contagious diseases..... A. M. or P. M.

19—Undertaker Mrs E J Conran

Place of Business 340 Madison

19664

*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 18.

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, Asthenia, 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.

16
DEC 20 1910

For

1.—F

2.—A

3.—S

5.—S

6.—B

8.—I

10.—F

12.—P

13.—N

15.—I H

16.—Cau

This Cert


igned by

* See ot

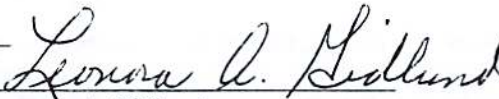
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