

PRIMARY DIST. NO. 23003-237

CERTIFICATE OF DEATH

1. DEATH OCCURRED IN: DELAWARE		a. County		b. City or borough		2. DECEASED'S MAILING ADDRESS		a. Street address, R. D., or Box Number					
c. If death did not occur in City or borough, give name of township (Do not use R. D. or Box Number)		UPPER DARBY				b. Post Office, Zone, and State		UPPER DARBY, PA					
d. Full Name of Hospital or institution (if not in hospital, give street address)		109 POWELL LANE				3. VETERAN		Yes <input type="checkbox"/>		NO <input checked="" type="checkbox"/>			
						a. Which War				b. Serial No.			
4. NAME OF DECEASED (Type or print)		a. (First)		b. (Middle)		c. (Last)		5. DATE OF DEATH		(Month) (Day) (Year)			
GEMMA CARLUCCI		GEMMA		CARLUCCI		1		AUG 27 1964					
6. WHERE DID DECEASED ACTUALLY LIVE?		a. State		b. County		c. Did deceased live in a township? <input type="checkbox"/> Yes, deceased lived in _____ township.							
		PA		DELAWARE		<input type="checkbox"/> No, deceased lived within actual limits of _____ city or borough.							
7. SEX		8. COLOR OR RACE		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. DATE OF BIRTH		11. AGE (in years last birthday)		If under 1 year		If under 24 hours	
FEMALE		W.		WIDOWED <input checked="" type="checkbox"/>		3-9-1904		60		Months		Days	
										Hours		Min.	
12. USUAL OCCUPATION (even if retired)		13. SOCIAL SECURITY NO.		14. BIRTHPLACE (State or foreign country)		15. CITIZEN OF WHAT COUNTRY?							
HOUSEWIFE		-		PENNA.		U.S.A.							
16. FULL NAME OF SPOUSE		17. MOTHER'S MAIDEN NAME											
QUERINO		UNK.											
18. FATHER'S NAME		19. INFORMANT'S NAME AND ADDRESS											
UNK.		JEAN SCHWALBER		109 POWELL LANE									

MEDICAL CERTIFICATE (Items 20 through 23 must be completed by physician only)

20. CAUSE OF DEATH: Enter only one cause per line for (a), (b) & (c).		INTERVAL BETWEEN ONSET AND DEATH	
PART I. Death was caused by:		36 HRS	
IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS			
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.		4 YEARS	
DUE TO (b) CORONARY ARTERY DISEASE			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS: contributing to death but not related to the immediate cause given in Part I (a)		21. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. a. ACCIDENT Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		22. b. DESCRIBE HOW ACCIDENT OCCURRED	
22. c. TIME OF ACCIDENT		Hour Month Day Year	
		m E.S.T.	
22. d. ACCIDENT OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		22. e. PLACE OF ACCIDENT (e.g., home, farm, street, etc.)	
22. f. CITY, BOROUGH, TOWNSHIP		COUNTY STATE	
23. I hereby certify that I attended the above named deceased and that death occurred from the causes and on the date stated above at 6:30^A M. D.			
a. Signature MELBA G. BETH		b. Address 649 S. 57th ST PHILA, PA	
c. Date signed AUG 28, 1964			
24. a. BURIAL CREMATION <input checked="" type="checkbox"/> REMOVAL <input type="checkbox"/>		24. b. DATE	
		8-31-64	
24. c. NAME OF CEMETERY OR CREMATORY		24. d. LOCATION (City, Boro., Twp., & County) (State)	
SAINT CECILIA'S CEM.		COTTESVILLE, CHESTER, PA.	
25. DATE REC'D BY REG.		26. REGISTRAR'S SIGNATURE	
8-29-64		Eleonora Ambrosio	
27. SIGNATURE AND ADDRESS OF FUNERAL DIRECTOR			
Robert J. D'Ally		6520 Homewood AVE	

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