

O.K.
 C.D.
 MARGIN RESERVED FOR BINDING
 WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificate.
 N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH
 County of *Womens Hosp.*
 Township of *Womens Hosp.*
 or
 Borough of
 or
 City of

Registration District No. *51*
 Primary Registration District No.

File No. *36951*
 Registered No. *09922*

[If death occurred in a Hospital or institution give its NAME instead of street, and number.]

2. FULL NAME *Theresa Rambo*
 (a) Residence, No. *6200 Vine St.* St., Ward
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE Years Months Days IF LESS than 1 day hrs. or min.
30

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *housewife*
 (b) General nature of industry, business or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (city or town) (State or Country) *U.S.A.*

10. NAME OF FATHER *Louis W. Andrea*

11. BIRTHPLACE OF FATHER (city or town) (State or Country) *Phila*

12. NAME OF MOTHER *Amelia Lico*

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) *Italy*

14. Informant (Address) *Josephine Parafin 231 So. 5th St.*

15. Filed *MAY 2 1936* Registrar *James H. Lyman*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *4 30*, 193*6*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That an inquest was held upon the body of the above named deceased on the _____ day of _____ 193____; that the jury rendered a verdict giving the cause of death* as follows: **INQUEST PENDING**

CONTRIBUTORY (Secondary) (duration) yrs. mos. days

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?
 (Signed) *Charles H. Hersch* Coroner
 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL *St. Rose Cemetery* DATE OF BURIAL *May 4 1936*

20. UNDERTAKER *Junie S. Guzzick* ADDRESS *210 N. 63rd*

(Over)