HVS-5H—250M—8-40

Primary Dist. No. (8) 1

600

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No. 42863

Registered No. 11016

MARGIN RESERVED FOR BINDING
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

1. PLACE OF DEATH:
(a) County Philadelphia
(b) City or borough or township Philadelphia
(c) Name of hospital or institution: Jefferson Hosp
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community 5 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington DC (b) County
(c) City or town
(If outside city or town limits, write RURAL)
(d) Street No. 119 Webster St. N. W.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) **FULL NAME** RACHEL MAHER 07

3. (b) If U. S. Veteran, complete reverse side of certificate

3 (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife James A. Maher
6 (c) Age of husband or wife if alive years
7. Birth date of deceased Jan. 1. 1865 (Month) (Day) (Year)
8. AGE: Years 76 Months 4 Days 21 If less than one day hr. min.
9. Birthplace Indiana (City, town, or county) (State or foreign country)
10. Usual occupation At home
11. Industry or business

FATHER
12. Name John T. Wilder
13. Birthplace New York (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Stewart
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edith N. Scott
(b) Address Media, Pa.
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 5/24/41 (Month) (Day) (Year)
(c) Place: burial or cremation West Laurel Hill
18. (a) Signature of funeral director Oliver H. Bair Co. / Glen J. Robinson
(b) Address 1820 Chestnut St.
19 (a) MAY 24 1941 (Date received local registrar) (b) Joseph A. Farrell (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month May day 22 year 1941 hour 12 minute 30 P.M.
21. I hereby certify that I attended the deceased from 5/17, 1941, to 5/22, 1941, that I last saw her alive on 5/22, 1941, and that death occurred on the date and hour stated above.

DURATION

Immediate cause of death
(1) Carcinoma Left Breast
(2) Diabetes Mellitus
Due to 50
Due to 61
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) (Probably) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Karl Kornblum (M. D. or other)
Address Jefferson Hosp Date signed
P. H. Gallant, M.D.