

PLACE OF DEATH

STATE OF NEW YORK

Department of Health of The City of New York

BUREAU OF RECORDS

STANDARD CERTIFICATE OF DEATH 5591

BOROUGH OF BronxName of Institution Bronx Wood Lawn

Register No. _____

FULL NAME Helen JacobsonSEX FemaleCOLOR OR RACE white5 SINGLE,
MARRIED,
WIDOWED,
or DIVORCED
(Write the word) widowed15 DATE OF DEATH June 24th 1932

(Month)

(Day)

(Year)

DATE OF BIRTH _____

(Month) _____ (Day) _____ (Year) _____

7 AGE 76If LESS than
1 day, _____ hrs.
1 day, _____ hrs.
ds. or _____ min.

8 OCCUPATION

a) Trade, profession or particular kind of work Housewife

b) General nature of industry, business or establishment in which employed (or employer) _____

c) No. of years so occupied _____

9 BIRTHPLACE

(State or country) Russia(A) How long in U.S. of foreign birth) 44 yrs.(B) How long resident in City of New York 44 years

PARENTS OF DECEASED

10 NAME OF FATHER Loefer Newman11 BIRTHPLACE OF FATHER (State or country) Russia12 MAIDEN NAME OF MOTHER Helen Cohen13 BIRTHPLACE OF MOTHER (State or country) Russia

14 Special INFORMATION required in deaths in hospitals and institutions and in deaths of non-residents and recent residents.

Former or usual residence) 887 Washington St. Brooklyn, N.Y.

Where was disease contracted, if not at place of death?

16 I hereby certify that the foregoing particulars (Nos. 1 to 15 inclusive) are correct as near as the same can be ascertained, and I further certify that deceased was admitted to this institution on June 23rd 1931, that I last saw her alive on the 24th day of June 1932, that she died on the 24th day of June 1932, about 6:30 o'clock A. M. or P. M., and that I am unable to state definitely the cause of death; the diagnosis during her last illness was:

Cerebral arterio-sclerosis
Cerebral arterio-sclerosis

duration _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Pneumonia

duration _____ yrs. _____ mos. _____ ds.

Witness my hand this 24 day of June 1932Signature Dr. S. M. M.D.House Physician

17 I hereby certify that I have this _____ day of _____ 19____, performed an autopsy upon the body of said deceased, and that the cause of death was as follows:

Signature _____ M.D.

Pathologist _____ Hospital _____

FILED GF18 PLACE OF BURIAL Mt. Carmel Cem.DATE OF BURIAL June 26 193219 UNDERTAKER Misikoff BrosADDRESS 1406 Pitkin Ave

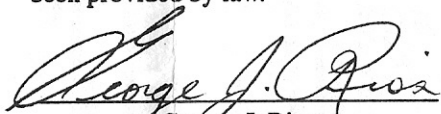
1771

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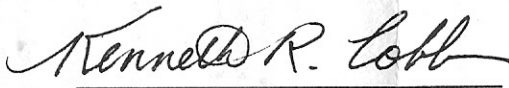
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George J. Rios

Commissioner, D.O.R.I.S.



Kenneth R. Cobb
Director, Municipal Archives