No. AA35536 -1933

Form 15 H

STATE OF NEW YORK

Department of Health of The City of New York

BUREAU OF RECORDS

STANDARD CERTIFICATE OF DEATH

Register No. 13203

1 PLACE OF DEATH

BOROUGH OF Manhattan

Name of Institution Mt Sinai Hosp

Address of Institution 100 St & 5 Ave

2 PRINT FULL NAME MONUS JACOBSON 13203

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)
male	white	married

5A WIFE / HUSBAND OF

6 DATE OF BIRTH OF DECEDENT ...., 1.... (Month) (Day) (Year)

7 AGE 67 yrs .... mos. .... ds. If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION
(a) Trade, profession or particular kind of work Rabbi
(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

9A How long in U. S. (if of foreign birth) 42 yrs — 9B How long resident in City of New York 42 yrs

PARENTS OF DECEASED

10 NAME OF FATHER OF DECEDENT Jacob Jacobson

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER OF DECEDENT Sarah Paretzkin

13 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.

Usual residence 622 W. 114 St

INFORMANT: Son

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

15 DATE OF DEATH May 29, 1934 (Month) (Day) (Year)

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 May 21, 1934, that I last saw him alive on the 29 day of May 1934, that he died on the 29th day of May 1934, about 4.15 o'clock A. M. ~~or P. M.~~, and that I am unable to state definitely the cause of death; the diagnosis during his last illness was:

Carcinoma of the Stomach

duration .... yrs. .... mos. .... ds.

Contributory (Secondary) Bronchopneumonia - Pulmonary Edema

duration 1 yrs. .... mos. .... ds.

Operation? yes 5/21 State kind Gastrotomy

Witness my hand this 29 day of May 1934

Signature Robert H. [illegible] M.D.

House Surgeon

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 h.... death was as follows:

Signature .... M.D.

Pathologist .... Hospital

FILED

18 PLACE OF BURIAL Riverside Cem

DATE OF BURIAL May 30, 1934

19 UNDERTAKER Hyse & Schwartz / David Schwartz

ADDRESS 1018 Prospect Av

NO MUTILATED CERTIFICATE WILL BE RECEIVED — MARGIN RESERVED FOR BINDING

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NEW YORK CITY DEPARTMENT OF RECORDS AND INFORMATION SERVICES
MUNICIPAL ARCHIVES
31 Chambers Street
New York, NY 10007

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In issuing this transcript 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.

George J. Rios
Commissioner, D.O.R.I.S.

Kenneth R. Cobb
Director, Municipal Archives