

N9AA35536

-1933

Form 15 H 1-20-33

STATE OF NEW YORK
Department of Health of The City of New York
BUREAU OF RECORDS

STANDARD CERTIFICATE OF DEATH 13203

Register No. 13203

1 PLACE OF DEATH

BOROUGH OF *Manhattan*

Name of Institution *Mt Sinai Hosp*

Address of Institution *100 Stuyvesant*

2 PRINT FULL NAME *MONUS JACOBSON*

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)

Married

15 DATE OF DEATH

May 29 1934
(Month) (Day) (Year)

5A WIFE OR HUSBAND OF

6 DATE OF BIRTH OF DECEDENT

Month) (Day) (Year)

7 AGE

67 yrs. mos. ds. or min.

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

(A) How long in U. S. (if of foreign birth) *42 yrs*

(B) How long resident in City of New York *42 yrs*

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?

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 *29* day of *May* 1934, about *11* o'clock A. M. ~~at~~, 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 *Smoking - Pulmonary Edema* (Secondary)

duration yrs. mos. ds. Operation? *yes* State kind *Gastrostomy*

Witness my hand this *29* day of *May* 1934

Signature *Robert H. Johnson, M.D.*

House *London*

17 I hereby certify that I have this *29* day of *May* 1934, performed an autopsy upon the body of said deceased, and that the cause of his death was as follows:

Signature _____ M.D.

Pathologist _____ Hospital _____

FILED

18 PLACE OF BURIAL

Riverside Cem

DATE OF BURIAL

May 30 1934

19 UNDERTAKER

David Schwartz

ADDRESS

1018 Prospect St

MARGIN RESERVED FOR BINDING NO MUTILATED CERTIFICATE WILL BE RECEIVED

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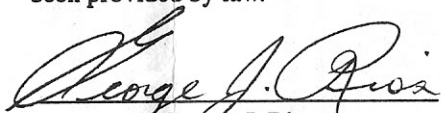
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MUNICIPAL ARCHIVES
31 Chambers Street
New York, NY 10007

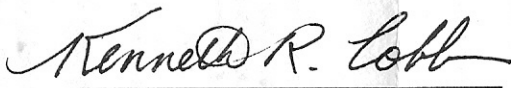
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In issuing this transcript of the record, the Department of Records and Information Services does not certify to the truth of the statements made thereon, as no inquiry to the facts has been provided by law.



George J. Rios

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



Kenneth R. Cobb

Kenneth R. Cobb
Director, Municipal Archives