

CERTIFICATE OF DEATH

199

REGISTRATION DISTRICT NO. 11-10		REGISTRAR'S CERTIFICATE NO.		
1. PLACE OF DEATH Swannanoa		b. TOWNSHIP Swannanoa	c. LENGTH OF STAY (in this place) 71 Days	
2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
c. CITY OR TOWN Silver Spring		Is Place of Residence Within City Limits? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF (If not in hospital or institution, give street address or location) Swannanoa Div., VA Hospital		d. STREET ADDRESS or R. F. D. NO. 2005 Newton Street		
4. DATE OF DEATH a. (First) Michael		b. (Middle) J.	c. (Last) CANTRELL	
4. DATE OF DEATH (Month) (Day) (Year) 1 - 5 - 53				
6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 1-15-94	9. AGE (In years last birthday) 59	
10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? USA		
13. OCCUPATION (Give kind of work during most of working life even if retired) Hospital		14. MOTHER'S MAIDEN NAME Molly Bignane		
15. DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) WWI & WWII	16. SOCIAL SECURITY NO. 238-42-2572	17. INFORMANT'S NAME AND ADDRESS Hospital Records Swannanoa Div., VAH, Oteen, H. C.		
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Insufficiency		Unknown		
ANTECEDENT CAUSES DUE TO (b) Coronary Arteriosclerosis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		Unknown		
DUE TO (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19b. MAJOR FINDINGS OF OPERATION As recorded above		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21d. HOW DID INJURY OCCUR?			
I hereby certify that I attended the deceased from 10-25-1952 to 1-5-1953, that I last saw the deceased alive on 1-5-1953, and that death occurred at 4:15 A.M., from the causes and on the date stated above.				
SIGNATURE R. H. KAPLAN, M.D.		(Degree or title)	23b. ADDRESS Swannanoa Div., VA Hospital Oteen, H. C.	23c. DATE SIGNED 1-6-53
24a. DATE	24b. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)		
25. FUNERAL DIRECTOR Taltavull Funeral Home, Washington, D.C.	ADDRESS			