

562

Primary Dist. No. 40-23-21

CERTIFICATE OF DEATH

Registered No. 5

1. PLACE OF DEATH a. COUNTY <b>Luzerne</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Penna</b> b. COUNTY <b>Luzerne</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGH <b>Swoyerville</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGH <b>Swoyerville</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>390 Main St.</b>			d. STREET ADDRESS (If rural, give location) <b>390 Main St.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Adam</b>		b. (Middle)		c. (Last) <b>Comorosky</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>March 2 1951</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec 9 1904</b>		9. AGE (In years last birthday) <b>47</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professional Athlete</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baseball</b>		11. BIRTHPLACE (Also give State or foreign country) <b>Luzerne, Penna</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Anthony Comorosky</b>		14. MOTHER'S MAIDEN NAME <b>Alice</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S OWN SIGNATURE <b>Mrs. Helen Comorosky</b> ADDRESS <b>390 Main St. Swoyerville, Pa</b>	
18. CAUSE OF DEATH					
Enter only one cause per line for (a), (b), and (c)					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Myocardial Failure</b>					
ANTECEDENT CAUSES DUE TO (b) <b>Coronary Disease</b>					
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <b>Syphilitic Cardiovascular Disease</b>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN AND TOWNSHIP) (COUNTY) (STATE)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct. 1, 1950</b> to <b>Mar. 3, 1951</b> , that I last saw the deceased alive on <b>Mar. 3, 1951</b> and that death occurred at <b>11:30 p.m., E.S.T.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>James M. Boyle</b>		M.D. or other <b>M.D.</b>		23b. ADDRESS <b>777 Bennett Ave. Pa.</b>	
23c. DATE SIGNED <b>Mar 5 '51</b>		24a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Mar 6 '51</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>St Ignatius Cemetery</b>		24d. LOCATION (Town, township and county) (State) <b>Pringle, Luzerne Co, Pa</b>			
DATE REC'D BY LOCAL REG. <b>March 5-51</b>		REGISTRAR'S SIGNATURE <b>Mrs. Frances Janczewski</b>		25. SIGNATURE OF FUNERAL DIRECTOR <b>Stella Betz</b> ADDRESS <b>568 Bennett St. Luzerne, Pa.</b>	

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.

FILE NO.		24 912	
CASE NO.		24 912	
NAME OF DECEASED <b>ADAM COMOROSKY</b>		DATE AND HOUR OF DEATH <b>MARCH 2, 1951 11:30 P</b>	
PLACE OF DEATH IN BALTIMORE AREA (If)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>PA</b> b. COUNTY <b>LUZERNE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>390 MAIN ST. SWOYERVILLE, PA.</b>		c. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SWOYERVILLE</b>	
d. STREET ADDRESS (If rural, give location) <b>390 MAIN ST.</b>		5. DATE OF BIRTH <b>DEC. 9, 1904</b>	
6. RACE <b>M</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. AGE (In years last birthday) <b>47</b>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROFESSIONAL ATHLETE - BASEBALL</b>		10. BIRTHPLACE (State or foreign country) <b>LUZERNE, PA</b>	
11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12. MOTHER'S MAIDEN NAME <b>ALICE</b>	
13. FATHER'S NAME <b>ANTHONY COMOROSKY</b>		14. MOTHER'S MAIDEN NAME <b>ALICE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>MRS. HELEN COMOROSKY</b> ADDRESS <b>390 MAIN ST. SWOYERVILLE, PA</b>		18. CAUSE OF DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<b>ACUTE MYOCARDIAL FAILURE</b>	
ANTECEDENT CAUSES		<b>CORONARY DISEASE</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>SYPHILITIC CARDIO-VASCULAR DISEASE</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>023 X</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19c. AUTOPSY? (Yes or No)		19d. IF YES, WHERE IT WAS PERFORMED IN CERTIFYING CAUSES OF DEATH?	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inch by medical examiner)		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR?		20d. HOW DID INJURY OCCUR?	
20e. TIME OF INJURY (APPROX)		20f. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>1951</b> that (I) (we) last saw the deceased alive on <b>1951</b> and that in (my) (our) opinion death occurred on the <b>2</b> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23a. SIGNATURE <b>JAMES M. BOYLE</b>		M.D. Attending Phys. <input type="checkbox"/> M.D. Dis. <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23c. PHYSICIAN'S NAME (Type) <b>JAMES M. BOYLE</b>		23d. ADDRESS <b>777 Bennett Ave. Luzerne, Pa.</b>	
24a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>3-6-51</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>ST. IGNATIUS CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>PRINGLE, LUZ. CO. PA.</b>	
DATE REC'D BY HEALTH DEPT. <b>MARCH 5-51</b>		25a. NAME OF REGISTRAR <b>MRS. FRANCES JANCZEWSKI</b>	
25b. NAME OF REGISTRAR <b>MRS. FRANCES JANCZEWSKI</b>		25c. FUNERAL DIRECTOR <b>STELLA BETZ</b> ADDRESS <b>568 BENNETT ST. LUZERNE</b>	