

## OHIO DEPARTMENT OF HEALTH

## DIVISION OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Reg. Dist. No. 1224State File No. 33416Primary Reg. Dist. No. 8493Registrar's No. 937

1. PLACE OF DEATH a. COUNTY <u>Summit</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Summit</u>		
b. CITY (If outside corporate limits, write RURAL OR and give township) VILLAGE <u>Akron</u>		c. LENGTH OF STAY (in this place) <u>30 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) VILLAGE <u>Akron</u>		d. STREET (If rural, give location) ADDRESS <u>280 E. Tallmadge Ave.</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Thomas Hospital</u>			4. DATE (Month) (Day) (Year) OF DEATH <u>May 14, 1949</u>		
3. NAME OF DECEASED (TYPE OR PRINT) <u>Michael</u>		a. (First)	b. (Middle) <u>Maheo</u>	c. (Last)	5. SEX <u>Male</u>
6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 3, 1873</u>		9. AGE (In years last birthday) <u>75</u>	Under 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Ballplayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Professional Baseball Player</u>	11. BIRTHPLACE (State or foreign country) <u>Yellow Springs, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Michael Maheo</u>			14. MOTHER'S MAIDEN NAME <u>Mary Cochran</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE <u>John Maheo</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES <u>Arteriosclerosis</u> <u>Chronic myocarditis</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4201</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>no op</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, forest, etc.)	21c. (CITY, VILLAGE, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	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 _____, 19____, to _____, 19____, and that death occurred at _____, from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>John C. Banker M.D.</u>			23b. ADDRESS <u>Akron Ohio</u>		23c. DATE SIGNED <u>5-15-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/17/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Akron Ohio</u>	
BIRTH NO. Do not write in this space			NAME OF EMBALMER (LIC. NO.) <u>C.W. Carr 5272A</u>		
DATE REC'D BY LOCAL REG. <u>5-17-49</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE (LIC. NO.) <u>[Signature] 510</u>		