

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **024 107-63**

1. DECEASED'S NAME (Type or Print) **JOHN CORTAZZO**
2. DATE AND HOUR OF DEATH **3-4-1963 12:30 P.M.**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
A. STATE **PA** B. COUNTY **ALLEG.**
C. CITY OR TOWN (If outside city limits, write RURAL and give township) **WILMERDING**
D. STREET ADDRESS (If rural, give location) **136 MIDDLE AVE.**

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **BRADDOCK GENERAL HOSP. BRADDOCK, PA**
6. RACE **M** **W**
7. MARRIAGE HISTORY (Specify) **WIDOWED**
8. DATE OF BIRTH **9-26-1904** 9. AGE (in years last birthday) **58**
10. USUAL OCCUPATION (Give kind of service, kind of business or industry during most of working life, even if retired) **LABOR**
11. BIRTHPLACE (State or foreign country) **WILMERDING, PA**
12. CITIZEN OR WHAT COUNTRY? **USA**

13. FATHER'S NAME **NICHOLAS CORTAZZO**
14. MOTHER'S MAIDEN NAME **ROSELLA CORTAZZO**
15. DECEASED'S SOCIAL SECURITY NO. **194-01-3315**
16. INFORMANT **TRAFFORD, PA**
WILLIAM CORTAZZO, 104 MEADOW DRIVE

17. SPOUSE **EMMA HAMMOND**
18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MASSIVE CEREBRAL HEMORRHAGE 15 HOURS
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
HYPERTENSIVE HEART DISEASE 6 MONTHS
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
CARDIAC HYPERTROPHY

19. DATE OF OPERATION
20. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No) **YES**
22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
23. ACCIDENT WAE UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (toify medical examined)
24. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)
25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
26. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
27. INJURY OCCURRED
While At Work Not While At Work
28. HOW DID INJURY OCCUR?

29. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____
that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

30. SIGNATURE
M.D. Attending Phys. Med. Director Staff Phys.
31. PHYSICIAN'S NAME (Type) **U. C. BARRETT**
32. ADDRESS **SWISSVALE**
33. DATE SIGNED **5-MAR. 63**

34. BURIAL CREMATION, REMOVAL (Specify) **BURIAL**
35. DATE **MAR 9 1963**
36. NAME OF CEMETERY OR CREMATORY **ST. JOSEPH CEM**
37. LOCATION (City, town, or county) (State) **E. MCKEESPORT, PA**
38. DATE REC'D BY HEALTH DEPT. **3-8-63**
39. NAME OF REGISTRAR **THEBESA DEBONE**
40. FUNERAL DIRECTOR **JAMES J. ALFIERI, WILMERDING, PA**