

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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 statements of OCCUPATION is very important. See instructions on back of certificate.

Form T. S. No. 1.—3-10-11.  
PLACE OF DEATH.

### CERTIFICATE OF DEATH.

COMMONWEALTH OF PENNSYLVANIA.  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS.

County of **PHILADELPHIA**,  
Township of .....  
or  
Borough of .....  
or  
City of **PHILADELPHIA**.

Registration District No. 1.  
Primary Registration District No. ....

File No. ....  
Registered No. **24369**

Hospital or Institution, **Philadelphia**  
**Edward Green**

#### 2. FULL NAME

#### PERSONAL AND STATISTICAL PARTICULARS

#### MEDICAL CERTIFICATE OF DEATH

3. SEX **male**  
4. COLOR OR RACE **white**  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**  
(Write the word.)

16. DATE OF DEATH **11 1 1912**  
(Month) (Day) (Year)

6. DATE OF BIRTH **1859**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **1912** to **11-1-1912** and that I last saw him alive on **11-1-1912** and that death occurred, on the date stated above, at **4:35 P. M.** The CAUSE OF DEATH\* was as follows:  
**Cirrhosis of Liver 113**

7. AGE **53**  
**49**  
Yrs. mos. ds.  
If LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION  
(a) Trade, profession, or particular kind of work **Electrician**  
(b) General nature of industry, business, or establishment in which employed (or employer)

Contributory (SECONDARY) .....  
(Duration) yrs. mos. ds.  
In deaths of children under 2 years of age, state if Breast fed or Artificially fed, (Signed) **H. J. Newcomb** M. D.  
**11-2-12** Address **Phila. Hopt.**

9. BIRTHPLACE (State or Country) **Philada.**

10. NAME OF FATHER **Edward M. Green**

11. BIRTHPLACE OF FATHER (State or Country) **New Jersey**

12. MAIDEN NAME OF MOTHER **Winters**

13. BIRTHPLACE OF MOTHER (State or Country) **New Jersey**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) **A. M. Tilly**  
(Address) **Phila. Hopt.**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

15. **NOV 4 1912**  
Filed.....1912.....

18. LENGTH OF RESIDENCE (For HOSPITALS AND INSTITUTIONS.)  
At place of death.....yrs. 2 mos. 11 ds. State.....yrs. mos. ds.  
Where was disease contracted, .....  
If not at place of death?.....  
Former or usual residence **1345 Carl St. Ward.**

19. PLACE OF BURIAL OR REMOVAL **Calver** DATE OF BURIAL **Nov. 31** 1912

20. UNDERTAKER **J. C. Shuler** ADDRESS **1419 E. Susquehanna**

Local Registrar