The Board of the Health Department of the City of Brooklyn has made the following Order:

"All permits for the removal of the Body of any deceased person from the City of Brooklyn for Interment, and all Burial Permits, and Permits for the Disinterment of the remains of deceased presons in the City of Brooklyn, shall be granted and signed by the Register of Records."

☞ "The Physician who attended any person in a last illness is responsible for the presentation of this Certificate, accurately filled out, to the BUREAU OF RECORDS OF VITAL STATISTICS, within *36 hours* after said person's death.

Write time from Attack till Death opposite EACH CAUSE. *If unknown, it should be so stated.* [See 139 of Sanitary Code.]

The IMMEDIATE CAUSE should be certified by the Physician when recognized as influencing the chief cause of Death.
No PERMIT FOR BURIAL WILL BE GRANTED WITHOUT A CERTIFICATE ACCURATELY FILLED OUT.

CERTIFICATE OF DEATH.

1. Full name of the Deceased, (Write legibly and spell correctly) *Charles Hodes*

2. Age, *27* years, _____ months, _____ days, Color, *White*

3. Single, *Married*, Widow or Widower, (Cross out the words not required on this line.)

4. Occupation, *Ball player*

5. Birthplace, *N. Y.* (And how long in the United States, if a foreign born.)

6. How long resident in this City, *21 yrs*

7. Father's Birthplace, (The State or Country) *Germany* *1555*

8. Mother's Birthplace, (The State or Country) *" "*

9. Place of Death, No. *474 Humboldt* Street, *15th* Ward.

10. Number of Families in House, _____

11. I Hereby Certify, That I attended deceased from *1874* to *Feb. 19th*

187 *that I last saw h* alive on the _____ day of _____ 187 : that *he died*
on the *14th* day of *Feb* 1875, about _____ o'clock, and that the cause of
h *is* Death was:

	Time from Attack till Death.
FIRST, (Primary,) *Phthisis Pulmonalis*	
SECOND, (Immediate,)	

ALL THE ABOVE INFORMATION MUST BE FURNISHED BY THE PHYSICIAN.

Place of Burial, _____

Date of Burial, _____ Signed by *James F. Leech* M.D.

Undertaker, _____ Medical Attendant.

Place of Business, _____ Address *296 Graham* *1*

Office of the Health Department, 66 Court Street.

[OVER]