

BETHLEHEM CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **24 912**

1. CASE NO.
 2. NAME OF DECEASED
 (Age or Post)

ADAM Comorosky

3. DATE AND HOUR OF DEATH
MARCH 2, 1951 11:30 P

4. PLACE OF DEATH (In Baltimore, give street)

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**390 MAIN ST.
 SWOYERVILLE, PA.**

5. USUAL RESIDENCE (Where deceased lived before residence before admission to hospital or institution)

**PA. LUZERNE
 SWOYERVILLE
 390 MAIN ST.**

6. MARRIAGE (If deceased was ever married, state date and how long married)

M W MARRIED

7. DATE OF BIRTH 8. AGE (In years, last birthday)

DEC. 9, 1904 47

9. USUAL OCCUPATION (Give kind of profession, business or industry during most of working life, even if retired)

10. SEX (State or foreign country)

PROFESSIONAL ATHLETE - BASEBALL

LUZERNE, PA U S A

11. FATHER'S NAME

ANTHONY Comorosky

12. MOTHER'S MARRIAGE NAME

ALICE - - - - -

13. Was deceased ever in U. S. Armed Forces? (Date or unknown) If yes, give war or dates of service

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14. SOCIAL SECURITY NO.

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15. INFORMANT

MRS. HELEN Comorosky, 390 MAIN ST. SWOYERVILLE, PA

16. 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.)

**CAUSE OF DEATH
 ACUTE MYOCARDIAL FAILURE
 DUE TO
 CORONARY DISEASE
 SYPHILITIC CARDIO-VASCULAR DISEASE**

17. INTERVAL BETWEEN ONSET AND DEATH

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18. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.

(B) DUE TO
 (C)

023 X

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. AUTOPSY? (Yes or No) 19D. IS THIS MORTUARY BUSINESS CONSIDERED IN CERTAINING CAUSES OF DEATH?

20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21A. TIME OF INJURY (APPROX.)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If not definite, give exact location)

21E. INJURY OCCURRED
 While At Work Not While At Work

21F. HOW DID INJURY OCCUR?

22. 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 _____ end hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE 23B. STATE SIGNED

23C. PHYSICIAN'S NAME (Type)

JAMES M. Boyle

23D. ADDRESS

M.D. 277 [can't read]

24. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORIUM 24D. LOCATION (City, town, or county) (State)

BURIAL 3-6-51 ST. IGNATIUS CEM. PRINGLE, LUZ. G. PA.

25. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS

MARCH 5-51 MRS. FRANCES JANCZEWSKI STELLA BETZ, 568 BENNETT

26. REV. 1/1/55 PER C.C. BETZ, SUPV. LUZERN