



The Commonwealth of Massachusetts

STATE DEPARTMENT OF PUBLIC HEALTH

REGISTRY OF VITAL RECORDS AND STATISTICS

483

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

The Commonwealth of Massachusetts STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH
 County Franklin State Mass Registered No. 84
 City or Town Morlague No. Farren Hospital St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward Barry
(If in the Army or Navy of the United States, give rank, organization, etc.)
 (a) Residence. No. _____ St. Ward Madison Wis
(Usual place of abode) (If non-resident give city or town and State)
 Length of residence in city or town where death occurred years _____ months _____ days _____
 How long in U. S., if of foreign birth? years _____ months _____ days _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Specify the word)

5a If married, widowed, or divorced
 HUSBAND of Helen Pasyd
 (or) WIFE of

6 DATE OF BIRTH October 2nd 1882
(Month) (Day) (Year)

7 AGE 37 Years 8 Months 15 Days
 If STILLBORN, enter that fact here If LESS than 1 day, less or min.
 If STILLBORN, state period of gestation _____ mo.

8 OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Stove Salesman
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer Otter River Stove Co

9 BIRTHPLACE (City) Madison
 (State or country) Wis

10 NAME OF FATHER James Barry

11 BIRTHPLACE OF FATHER (City) Madison
 (State or country) Wis

12 MAIDEN NAME OF MOTHER Sarah Sweeney

13 BIRTHPLACE OF MOTHER (City) Madison
 (State or country) Wis

14 Informant Mrs Edward Barry
 (Address) Gainsville Wis

15 Filed June 24, 1920 H. D. Goodwell
(Month) (Day) (Year) REGISTRAR

21 I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued
C. N. B. Fournier Official position Agt B of H. Date of issue of permit _____
 Permitted _____ No. _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 19th 1920.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1920 to June 19, 1920,
 that I last saw him alive on June 19, 1920,
 and that death occurred, on the date stated above, at 3-A.M.
 The CAUSE OF DEATH was as follows:
61-6

Cerebro Spinal Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18 Where was disease contracted Do not know
 if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. A. McGillicuddy M.D.
 (Address) Turners Falls Mass

Died June 19th 1920.
(Month) (Day) (Year)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Madison Wis, DATE OF BURIAL June 22, 1920
(Cemetery) (City or town)

20 UNDERTAKER Eugene McCarthy, ADDRESS Greenfield Mass

THIS IS TO BE KEPT AS A PERMANENT RECORD. Every item of information should be stated EXACTLY. Full names should give CAUSE OF DEATH whenever it can be ascertained. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.