

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 3848

(121)

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) Theodore Cather 2. DATE AND HOUR OF DEATH 4/9/45 M.

3. PLACE IN ~~STATE~~ MARYLAND, WHERE PRONOUNCED DEAD Unit 10  
 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Hosp Elkton

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
 A. STATE MD B. COUNTY Cecil  
 C. CITY OR TOWN Charleston D. INSIDE CITY LIMITS? YES  NO   
 E. STREET AND NUMBER \_\_\_\_\_

5. SEX M 6. RACE W 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED

8. DATE OF BIRTH 45 5/20/89 9. AGE (In years last birthday) 55 If Under 1 Yr. Months: \_\_\_\_\_ Days: \_\_\_\_\_ If Under 24 Hrs. Hours: \_\_\_\_\_ Min. \_\_\_\_\_

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store keeper 10B. KIND OF BUSINESS OR INDUSTRY owner 11. BIRTHPLACE (State or foreign country) Pa 12. CITIZEN OF WHAT COUNTRY \_\_\_\_\_

13. FATHER'S NAME Samuel Coker 14. MOTHER'S MAIDEN NAME Mary Physick

15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT Clare B Cather ADDRESS Charleston Md

18. CAUSE OF DEATH

I 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.)

(A) IMMEDIATE CAUSE Coronary thrombosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr.  
 DUE TO, OR AS A CONSEQUENCE OF: \_\_\_\_\_

ANTECEDENT CAUSES

(B) ?? DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION last. DUE TO, OR AS A CONSEQUENCE OF: \_\_\_\_\_

(C) \_\_\_\_\_

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 3/3/45 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal abscess 20A. AUTOPSY? (Yes or No) \_\_\_\_\_ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? \_\_\_\_\_

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) \_\_\_\_\_ 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 date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE \_\_\_\_\_ 23B. DATE SIGNED \_\_\_\_\_

DEPT. Attending Phys.  Med. Director  Staff Phys.

23C. PHYSICIAN'S NAME (Type) \_\_\_\_\_ 23D. ADDRESS \_\_\_\_\_

24A. BURIAL CREMATION, REMOVAL (Specify) \_\_\_\_\_ 24B. DATE 4/12 24C. NAME OF CEMETERY or CREMATORY Charleston 24D. LOCATION (City, town, or county) (State) \_\_\_\_\_

25A. DATE REC'D BY HEALTH DEPT. \_\_\_\_\_ 25B. NAME OF REGISTRAR \_\_\_\_\_ 25C. FUNERAL DIRECTOR Lee A. Patterson ADDRESS Perryville