

CERTIFICATE OF DEATH

Registered No. _____

BIRTH DATE M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
CLIFTON E. HEATHCOTE		JAN. 18, 1939 9:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
36 E. PRINCESS ST. YORK, PA		PA. YORK YORK YORK 36 E. PRINCESS ST.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
M	W	MARRIED	JAN. 24, 1898
9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
40			PA.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
SPURGEON E. HEATHCOTE		ANNIE E. KRAFT	
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 ADDRESS
			MILDRED H. HEATHCOTE, YORK, PA
18. SPOUSE - MILDRED H.		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO	
PULMONARY EMBOLISM			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO	
		111 2 130	
(C) DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
ACUTE GLOMERULO-NEPHRITIS			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (to be certified by 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) (Year) (Hour)	21E. INJURY OCCURRED (White At Work) (Not White 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
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Print)			23D. ADDRESS
E. P. FLANDERS			M.D. 34 E. PRINCESS ST. YORK, PA.
24A. BURIAL OR CREMATION (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
	JAN. 21, 1939	MT. CARMEL	ADAMS CO. PA.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
1-20-1939	FRED A. SCHIDING	C. A. STRACK & SON, YORK, PA.	