

Primary **S101-461**
Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PHILA DELAWIA			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE PENNA b. COUNTY PHILA.		
b. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGH Phila.		c. LENGTH OF STAY (In this place) 64 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGH PHILA.		d. STREET ADDRESS (If rural, give location) 124 W. DURHAM ST.
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 124 W. Durham St					
3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) BARBARA c. (Last) KAELEIN			4. DATE OF DEATH (Month) (Day) (Year) FEB. 3 1952		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 22, 1868	9. AGE (In years last birthday) 83	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (Also give State or foreign country) SWITZERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME NON ASCERTAINABLE			14. MOTHER'S MAIDEN NAME NON ASCERTAINABLE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	17. INFORMANT'S OWN SIGNATURE AND ADDRESS Mrs. Elsie Rupp 124 W. Durham St.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL THROMBOSIS ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) CARDIAC DECOMPENSATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 332X 3 yrs.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN AND TOWNSHIP) (COUNTY) (STATE)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> m. E.S.T.		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from DEC. 1942 , to 2-3-52 , that I last saw the deceased alive on FEB. 2, 1952 , and that death occurred at 12:00 m. E.S.T., from the causes and on the date stated above.					
23a. SIGNATURE Elaine M. Central D.O.		23b. ADDRESS 4 E. Mt. Pleasant Ave.		23c. DATE SIGNED 2-3-52	
24a. BURIAL CREMA-TION, REMOVA (Specify) Burial		24b. DATE Feb 6, 1952	24c. NAME OF CEMETERY OR CREMATORY Whitmarsh New York		24d. LOCATION (Town, township and county) (State) Prospectville Monty Co. Pa
DATE REC'D BY REGISTRY FEB 4 1952		REGISTRAR'S SIGNATURE Joseph A. Farrell		25. SIGNATURE OF FUNERAL DIRECTOR John R. Henderson ADDRESS 6301 4th Ave Huk + Mace Phila 44	

MARGIN RESERVED FOR BINDING
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important.

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