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WASHINGTON STREET

PAGE 01

STATE FILE NUMBER

NEW YORK STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

5922

57

1. NAME (LAST, FIRST, MIDDLE) MINNIE WILLIAMS

2. PLACE OF DEATH (Street and city) LAWRENCE HOSPITAL BRONXVILLE WESTCHESTER

3. DATE OF DEATH (Month, Day, Year) 4 9 18 77

4. SEX (Male or Female) FEMALE

5. RACE (White, Black, Other) Black

6. SOCIAL SECURITY NUMBER 316-50-4060

7. US BIRTH STATE AND COUNTY (If born in U.S.) NEW YORK WESTCHESTER

8. US BIRTH CITY AND COUNTY (If born in U.S.) BRONXVILLE WESTCHESTER

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10. US BIRTH CITY AND COUNTY (If born in U.S.) BRONXVILLE WESTCHESTER

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36. US BIRTH CITY AND COUNTY (If born in U.S.) BRONXVILLE WESTCHESTER

004-1981 (1/83)

Local No. 69 C921

MEDICAL CERTIFICATE OF DEATH

State No.

PERMANENT INSTRUCTIONS SEE HANDBOOK FOR INSTRUCTIONS

DECLAIED NAME: **JAMES B Williams** SEX: **M** DATE OF DEATH (MONTH, DAY, YEAR): **6-29-69**

RACE: **NEGRO** AGE - LAST BIRTHDAY (YEARS, MONTHS, DAYS): **53** UNDER 1 YEAR: **0** UNDER 1 DAY: **0** DATE OF BIRTH (MONTH, DAY, YEAR): **12-7-15** COUNTY OF DEATH: **LAKE**

DECLAIED: **GARY** HOSPITAL OR OTHER INSTITUTION - NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): **METHODIST**

7b. **YES** 7c. **YES** 7d. **MARRIED** SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME): **JANE Williams**

8. **LOUISIANA** 9. **U.S.** 10. **MARRIED** 11. **JANE Williams**

USUAL RESIDENCE WHEN DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION GIVE RESIDENCE BEFORE ADMISSION: **12435-03-0709** 12b. **GARY-SCREWT BOLT** 13b. **STEEL**

14a. **IND** 14b. **LAKE** 14c. **GARY** 14d. **YES** 14e. **CAHUMET**

14. **2269 VERMONT** 14f. **NO**

PARENTS: 15. **John Williams** 16. **Sarah Williams**

17a. **JANE Williams** 17b. **WIFE** 17c. **2269 VERMONT GARY**

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

18. (a) **Hypertensive Heart Disease** APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: **8 years**

(b) **off**

(c) **off**

PART II. OTHER SIGNIFICANT CONDITIONS: **Chronic Glomerulonephritis**

CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE: **Chronic Glomerulonephritis**

AUTOPSY (YES OR NO): **NO** 19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH: **NO**

DEATH OCCURRED (HOUR): **6:29** THE DECEDENT WAS PRONOUNCED DEAD (MONTH, DAY, YEAR): **6 29 1969** DATE SIGNED (MONTH, DAY, YEAR): **July 1, 1969**

CERTIFIER: 22a. **DR. ADOLPH GOLDSTONE** 22b. **Adolph Goldstone M.D.**

MAILING ADDRESS - CERTIFIER: 23. **3429 Broadway** City/Town: **Grey** State: **Indiana** ZIP: **46409**

BURIAL: 24a. **Reburial** 24b. **Greenwood Park** 24c. **Nobart Rd** 24d. **255**

DATE (MO., DAY, YEAR): **7-5-69** 25a. **Greenwood** 25b. **934 E 21st Ave S** 25c. **46407**

SEP-23-1997 11:16

800 853 2262

EMERGENCY NAME: **Williams** LICENSE NO. **9230**

709

RAL DIRECTOR'S LICENSE NO. **607**

99%

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