RETURN TO THE PROPER LOCAL REGISTRAR.

1898

STATE OF DELAWARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

92

1 PLACE OF DEATH

County New Castle

Hundred " "

or Village Fairhurst

or City

No. Castle County Hospital Ward.

2 FULL NAME Wm. H. Haggerid

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. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word):

6 DATE OF BIRTH: ..... (Month), ... (Day), 19 ..... (Year)

7 AGE: 60 yrs. ..... mos. ..... ds. If less than 1 day, ... hrs. or ..... min.

8 OCCUPATION
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer): Day Laborer

9 BIRTHPLACE (State or country): Delaware

PARENTS

10 NAME OF FATHER: No record

11 BIRTHPLACE OF FATHER (State or country): " "

12 MAIDEN NAME OF MOTHER: " "

13 BIRTHPLACE OF MOTHER (State or country): " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis B. Racine

(Address) Fairhurst

15

Filed, ..., 19.....

LOCAL SUB-REGISTRAR

Filed, Apr. 26th, 1919

LOCAL REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month), 25 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April (Month), 9 (Day), 1919, to April (Month), 25 (Day), 1919,

that I last saw him alive on April, 25, 1919,

and that death occured, on the date stated above, at ..... A. M. 5 P. M.

The CAUSE OF DEATH * was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Mayo M. D.

Apr. 25, 1919 (Address) Wilmington

* State the Disease Causing Death, or, in deaths from Violent Causes, State (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 16 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Silverbrook Cem

DATE OF BURIAL: 4-28-19

20 UNDERTAKER: James T. Chandler

ADDRESS: Del