

# CERTIFICATE OF DEATH.

DIST. No.

CLASS No.

1930 APR 28 PM 12 03  
DISTRICT OF COLUMBIA

No. OF RECORD

24002

FULL INSTRUCTIONS FOR THE GUIDANCE OF THOSE USING THIS BLANK AND SPACE FOR REMARKS MAY BE FOUND ON THE OTHER SIDE.

1 PLACE OF DEATH

No. Norfolk, Va. Street, ..... Section  
Name of Hospital Mt. Sinai Duration of residence therein.....

2 FULL NAME Harry F. Mace

(a) Residence No. .... Street .....  
(Usual Place of abode) (If nonresident give city or town and state)  
Length of residence in D. of C. yrs. mos. ds. How long in U. S. if of Foreign Birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
6A If married, widowed, or divorced HUSBAND of (or) WIFE of				
6 DATE OF BIRTH (month, day and year) <u>About 1870</u>				
7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or..... min.
	<u>60</u>			

8 OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Mechanic  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer.

9 BIRTHPLACE, (City or Town) Wash. D.C.  
(State or Country)

10 NAME OF FATHER (in full) Wm. Mace  
11 BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. MD.  
12 MAIDEN NAME OF MOTHER (in full) Elizabeth Breen  
13 BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash. D.C.

14 Above information furnished by.....  
(Address)

15 Relation of informant to decedent.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from ..... 18..... to..... 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at..... m. The CAUSE OF DEATH\* was as follows:

Pulmonary Embolus following Prostatotomy..... (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs..... mos..... ds.

18 Where was disease contracted if not at place of death.....

Did an operation precede death?..... Date of operation.....

Was there an autopsy?.....

What laboratory test confirmed diagnosis?..... (Signed) P. S. Schenck, Local Reg. A. M. D. (Address) Norfolk, Va.

\* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE  
Glenwood Cemetery 4-29-30

20 UNDERTAKER Thos. S. Sargent  
Address 1011 7th St. N.W.