25-2609-19-B, Form 15 M

1 PLACE OF DEATH

STATE OF NEW YORK

Department of Health of The City of New York

BUREAU OF RECORDS

STANDARD CERTIFICATE OF DEATH

BOROUGH OF Brooklyn N.Y.

Name of Institution St. Mary's Hospital.

Register No. 19353

2 FULL NAME Philip Reardon

3 SEX Male

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word) Single

6 DATE OF BIRTH , 1 (Month) (Day) (Year)

7 AGE 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

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

9 BIRTHPLACE (State or country) United States

(9 A) How long in U.S. (if of foreign birth)

(9 B) How long resident in City of New York Life

PARENTS OF DECEASED

10 NAME OF FATHER Dennis Reardon

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah Cronin

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 Special INFORMATION required in deaths in hospitals and institutions and in deaths of non-residents and recent residents.

Former or usual residence 456 - 8th St.

Where was disease contracted, if not at place of death? 456 - 8th St.

15 DATE OF DEATH September 28, 1920 (Month) (Day) (Year)

16 *I hereby certify that the foregoing particulars (Nos. 1 to 15 inclusive) are correct as near as the same can be ascertained, and I further certify that deceased was admitted, to this institution on* September 20 1920, *that I last saw him alive on the* 28 *day of* September 1920, *that he died on the* 28 *day of* September 1920, *about* 9 *o'clock A. M. or P. M., and that I am unable to state definitely the cause of death; the diagnosis during his last illness was:*

Acute dilatation of Heart

duration yrs. mos. 1 ds.

Contributory (Secondary) Chronic Myocarditis; Chronic Nephritis

duration yrs. 3 mos. ds.

Witness my hand this 28 day of Sept 1920

Signature Clifton L. Dance M.D.

House Physician

17 *I hereby certify that I have this ...... day of ...... 19 ...., performed an autopsy upon the body of said deceased, and that the cause of h...... death was as follows:*

Signature M.D.

Pathologist Hospital

FILED

18 PLACE OF BURIAL Holy Cross Cemetery

DATE OF BURIAL Sept 30, 1920

19 UNDERTAKER Cronin

ADDRESS 173 Atlantic Ave