REGISTER NUMBER 460

CERTIFICATE OF DEATH

093219

1 NAME: FIRST William MIDDLE F. LAST Skiff

2 SEX: MALE [X] 1 FEMALE [ ] 2

3A DATE OF DEATH: MONTH 12 DAY 25 YEAR 76

3B HOUR 4 A. M.

4 RACE: WHITE, BLACK, AMERICAN INDIAN, OTHER (SPECIFY): White

5 AGE: 83 YEARS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 1 DAY: HOURS MINUTES

6 DECEDENT BORN: MONTH 9 DAY 18 YEAR 1893

7 VETERAN OF U. S. ARMED FORCES? NO [X] YES [ ] IF YES, SPECIFY WAR OR DATES OF SERVICE

8A COUNTY OF DEATH: West.

8B LOCALITY (CHECK ONE AND SPECIFY): [ ] CITY OF [ ] TOWN OF [X] VILLAGE OF Bronxville

8C HOSPITAL OR OTHER INSTITUTION (IF NEITHER, GIVE ADDRESS): Lawrence Hospital

8D IF IN HOSPITAL (CHECK ONE): 1 [ ] D O A 2 [ ] EMERGENCY ROOM 3 [ ] OUTPATIENT 4 [X] INPATIENT

8E IF INPATIENT, ADMISSION DATE: MONTH 10 DAY 12 YEAR 76

9 STATE OF BIRTH (COUNTRY IF NOT USA): New York

10 CITIZEN OF WHAT COUNTRY? U.S.A.

11 MARITAL STATUS (CHECK ONE): 1 [ ] NEVER MARRIED 2 [ ] MARRIED 3 [X] WIDOWED 4 [ ] DIVORCED

12 SURVIVING SPOUSE (IF WIFE GIVE MAIDEN NAME)

13A USUAL OCCUPATION (EVEN IF RETIRED): Ret. Player Personal Advisor

13B KIND OF BUSINESS OR INDUSTRY: N.Y. Yankees

13C SOCIAL SECURITY NUMBER: 134-09-3512

14 EDUCATION: INDICATE HIGHEST GRADE COMPLETED — ELEMENTARY OR SECONDARY (0-12): 12 — COLLEGE (1 - 4 OR 5+):

RESIDENCE

15A STATE: New York

15B COUNTY: West.

15C LOCALITY (CHECK ONE AND SPECIFY): [X] CITY OF [ ] TOWN OF [ ] VILLAGE OF Yonkers

15D IF CITY OR VILLAGE, WITHIN CITY OR VILLAGE LIMITS? YES [ ] NO [ ] IF NO, SPECIFY TOWN

15E STREET AND NUMBER: 1470 Midland Ave

PARENTS

16A NAME OF FATHER: FIRST David MIDDLE T. LAST Skiff

16B MAIDEN NAME OF MOTHER: FIRST Margaret MIDDLE LAST Connor

17A NAME OF INFORMANT: Gertrude Mary Lapham

17B MAILING ADDRESS (INCLUDE ZIP CODE): 59 A Locust Ave. New Rochelle, N.Y.

DISPOSITION

18A BURIAL [X] CREMATION [ ] REMOVAL [ ]

MONTH 12 DAY 28 YEAR 76

18B PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Mount Cemetery

18C LOCATION (CITY OR TOWN, STATE): Eastchester, N.Y.

19A NAME AND ADDRESS OF FUNERAL HOME: Fred H. McGrath & Son. Inc. 20 Cedar St. Bronxville, N.Y.

19B REGISTRATION NO. 01617

20A NAME OF FUNERAL DIRECTOR: Robert W. McGrath

20B SIGNATURE OF FUNERAL DIRECTOR: Robert W McGrath

20C REGISTRATION NO. 03606

21A SIGNATURE OF REGISTRAR: Mary Ann Unico 2nd

21B DATE FILED: MONTH 12 DAY 27 YEAR 76

22A BURIAL OR REMOVAL PERMIT ISSUED BY: Mary Ann Unico 2nd

22B MONTH 12 DAY 27 YEAR 76

CERTIFIER

23 TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY

A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED — MONTH 12 DAY 25 YEAR 76

SIGNED William Buchan M.D.

B. THE PHYSICIAN ATTENDED THE DECEASED — FROM: MONTH 10 DAY 25 YEAR 76 TO: MONTH 12 DAY 25 YEAR 76

C. LAST SEEN ALIVE — MONTH 12 DAY 24 YEAR 76

D. NAME OF ATTENDING PHYSICIAN, IF OTHER THAN CERTIFIER

—OR—

23 TO BE COMPLETED BY CORONER OR MEDICAL EXAMINER ONLY

A. ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED.

SIGNED ..... TITLE .....

B. PRONOUNCED DEAD — ON MONTH DAY YEAR — AT HOUR M.

C. HOUR

D. DATE SIGNED — MONTH DAY YEAR

E. NAME OF CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER

24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, CORONER, MEDICAL EXAMINER, CORONER'S PHYSICIAN, MEDICAL DIRECTOR): William Buchan, M.D. 12 Studio Arcade, Bronxville N.Y. 10708

CAUSE

25 DEATH WAS CAUSED BY — ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).

		APPROXIMATE INTERVAL BETWEEN ONSET & DEATH
PART 1. IMMEDIATE CAUSE (A)	Left cerebral infarction	2 1/2 months
DUE TO, OR AS A CONSEQUENCE OF: (B)	cerebral arteriosclerosis	unknown
DUE TO, OR AS A CONSEQUENCE OF: (C)		

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART 1 (A): arteriosclerotic heart disease

26A AUTOPSY? YES [ ] 1 NO [X] 2

26B IF YES, WERE FINDINGS CONSIDERED IN DETERMINING THE CAUSE OF DEATH? YES [ ] NO [ ]

27A SPECIFY IF ACCIDENT, HOMICIDE, SUICIDE, UNDETERMINED, PENDING INVESTIGATION: NO

27B DATE OF INJURY: MONTH DAY YEAR

27C HOUR OF INJURY: M.

27D DESCRIBE HOW INJURY OCCURRED.

27E INJURY AT WORK? YES [ ] NO [X]

27F PLACE OF INJURY: HOME, FACTORY, OFFICE BLDG., ETC.

27G LOCATION (STREET & NO., CITY OR VILLAGE, TOWN, COUNTY, STATE)