THIS CERTIFICATE NOT VALID UNLESS FILED IN THE HEALTH DEPARTMENT
DO NOT WRITE IN THIS SPACE. MARGIN RESERVED FOR CODING AND BINDING

1771—1948

Born-Death 1

stitution 154

Born Resid. 2

Area-Dist. 2404

Occupation

Nativ. Dec. 02

Citiz. Dec.

Nativ. Mother 02

Cause 1 1A 155

Cause 2

peration 0

Type Accid.

O. T. Accid.

Aut.-Autop 1

V

BUREAU OF RECORDS
DEPARTMENT OF HEALTH
BOROUGH OF MANHATTAN

Certificate of Death

14419

FILED

Certificate No.

4 NAME OF DECEASED (Print or Type-write) GUSTAVE (First Name) (Middle Name) GLICKSTEIN (Last Name) (Social Security Number)

PERSONAL PARTICULARS
(To be filled in by Funeral Director)

3 USUAL RESIDENCE: (a) State NEW YORK (b) Co. BRONX (c) Post Office and Zone (d) No. 75 W. MOSHOLU PKWAY Ave. or St. (If in rural area, give location) (e) Length of residence or stay in City of New York immediately prior to death 50 YRS

3 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

4 WIFE of HUSBAND TILLIE

5 DATE OF BIRTH OF DECEDENT (Month) JAN (Day) 12 (Year) 1870

6 AGE 78 yrs. 5 mos. 11 days If LESS than 1 day, hrs. or min.

7 Occupation — A Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. RETIRED
B Industry or business in which work was done, as silk mill, sawmill, bank, own business, etc. GLASS INDUSTRY

8 BIRTHPLACE OF DECEDENT: (a) State AUSTRIA (b) County (c) City, Town or Village

9 OF WHAT COUNTRY WAS DECEDENT A CITIZEN AT TIME OF DEATH? U.S.

10 WAS DECEASED WAR VETERAN? IF SO, NAME WAR NO

Parents of Deceased

11 NAME OF FATHER OF DECEDENT JACOB

12 BIRTHPLACE OF FATHER (State or country) AUSTRIA

13 MAIDEN NAME OF MOTHER OF DECEDENT ELKA REINER

14 BIRTHPLACE OF MOTHER (State or country) AUSTRIA

15 INFORMANT: WILLIAM GLICKSTEIN | RELATIONSHIP TO DECEASED SON | ADDRESS 390 W END AVE

16 PLACE OF BURIAL OR CREMATION MT. CARMEL CEMETERY | DATE OF BURIAL OR CREMATION JUNE 24, 1948

17 FUNERAL DIRECTOR [illegible] | ADDRESS 150 West 76th St | PERMIT NUMBER 105

MEDICAL CERTIFICATE OF DEATH
(To be filled in by the Physician)

18 PLACE OF DEATH:
(a) NEW YORK CITY: (b) Borough Manhattan
(c) Name of Hospital or Institution Jewish Memorial Hosp (If not in hospital or institution give street and number)
(d) If in hospital, give Ward No.
(e) Length of stay at place of death immediately prior to death 14 days

17 DATE AND HOUR OF DEATH (Month) June (Day) 23 (Year) 1948 (Hour) 2:45 A.M.

18 SEX M | 19 COLOR OR RACE W | 20 Approximate Age 78

21 I HEREBY CERTIFY that (I attended the deceased)* (a staff physician of this institution attended the deceased)* from June 10 1948, to June 23 1948, and last saw h[illegible] alive at 2:45 A.M. on June 23 1948

I further certify that death † Was not caused, directly or indirectly by accident, homicide, suicide, acute or chronic poisoning, or in any suspicious or unusual manner, and that it was due to NATURAL CAUSES more fully described in the confidential medical report filed with the Department of Health.

* Cross out words that do not apply.
† See first instruction on reverse of certificate.

Witness my hand this 23rd day of June 1948

Signature William L. Strauss M. D.

Address Jewish Memorial Hospital

BUREAU OF RECORDS AND STATISTICS — DEPARTMENT OF HEALTH — CITY OF NEW YORK