

CENSUS TRACT
CUB-DIVISION

STATISTICAL DISTRICT
REC.
RES.

A
B
C
D

USUAL RESIDENCE WHERE DECEDENT LIVED.

E

F

G

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (A) STATING THE UNDERLYING CAUSE LAST.

H

I

J

NEW YORK STATE
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

RECORDED DISTRICT
1401
REGISTER NUMBER
6672

1 NAME: FIRST William H. McShane		MIDDLE William H. McShane		LAST William H. McShane		2 SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>		3A DATE OF DEATH MONTH 2 DAY 1 YEAR 77			3B HOUR 9:15 P.												
4 RACE: WHITE, BLACK, AMERICAN INDIAN, OTHER (SPECIFY) White		5 AGE 77 YEARS		IF UNDER 1 YEAR MONTHS 10 DAYS 9		IF UNDER 1 DAY HOURS 9 MINUTES 10		6 DECEDENT BORN MONTH 10 DAY 9 YEAR 99		7 VETERAN OF U. S. ARMED FORCES? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES IF YES, SPECIFY WAR OR DATES OF SERVICE													
8A COUNTY OF DEATH Erie		8B LOCALITY (CHECK ONE AND SPECIFY) <input type="checkbox"/> CITY OF Buffalo <input type="checkbox"/> TOWN OF <input type="checkbox"/> VILLAGE OF		8C HOSPITAL OR OTHER INSTITUTION (IF NEITHER, GIVE ADDRESS) Buffalo, Mercy		8D IF IN HOSPITAL (CHECK ONE) <input type="checkbox"/> D O A <input type="checkbox"/> EMERGENCY ROOM <input checked="" type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT		8E IF INPATIENT, ADMISSION DATE MONTH 12 DAY 28 YEAR 76															
9 STATE OF BIRTH (COUNTRY IF NOT USA) Maryland		10 CITIZEN OF WHAT COUNTRY? U.S.		11 MARITAL STATUS (CHECK ONE) <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		12 SURVIVING SPOUSE (IF WIFE GIVE MAIDEN NAME) Adelaide Crosta																	
13A USUAL OCCUPATION (EVEN IF RETIRED) Supervisor (Ret)		13B KIND OF BUSINESS OR INDUSTRY Steel Plant		13C SOCIAL SECURITY NUMBER 070-10-1632		14 EDUCATION: INDICATE HIGHEST GRADE COMPLETED ELEMENTARY OR SECONDARY 8 (0-12) COLLEGE (1-4 OR 5+)																	
15A STATE N.Y.		15B COUNTY Erie		15C LOCALITY (CHECK ONE AND SPECIFY) <input type="checkbox"/> CITY OF <input type="checkbox"/> TOWN OF <input checked="" type="checkbox"/> VILLAGE OF Hamburg		15D IF CITY OR VILLAGE WITHIN CITY OR VILLAGE LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SPECIFY TOWN																	
16A NAME OF FATHER: FIRST William MIDDLE H. LAST McShane		16B MAIDEN NAME OF MOTHER: FIRST Emmeline MIDDLE Price LAST Price																					
17A NAME OF INFORMANT: Mrs. William McShane		17B MAILING ADDRESS (INCLUDE ZIP CODE) 102 Maple Ave, Hamburg, N.Y. 14075																					
18A BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>		MONTH 2 DAY 4 YEAR 77		18B PLACE OF BURIAL, CREMATION OR REMOVAL SS. Peter & Paul		18C LOCATION (CITY OR TOWN, STATE) Hamburg, N.Y.																	
19A NAME AND ADDRESS OF FUNERAL HOME Donald M. Demmerley F.H. 21 Pierce Ave, Hamburg, N.Y.		19B REGISTRATION NO. 00626																					
20A NAME OF FUNERAL DIRECTOR: Donald M. Demmerley		20B SIGNATURE OF FUNERAL DIRECTOR <i>Donald M. Demmerley</i>		20C REGISTRATION NO. 01328																			
21A SIGNATURE OF REGISTRAR <i>[Signature]</i>		21B DATE FILED MONTH 2 DAY 5 YEAR 77		22A BURIAL OR REMOVAL PERMIT ISSUED <i>[Signature]</i>		22B MONTH 2 DAY 5 YEAR 77																	
23 TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY -OR- TO BE COMPLETED BY CORONER OR MEDICAL EXAMINER ONLY																							
A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED SIGNED <i>[Signature]</i> MONTH 2 DAY 3 YEAR 77												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. THE PHYSICIAN ATTENDED THE DECEASED FROM: MONTH 10 DAY 26 TO: MONTH 2 DAY 1 YEAR 77												B. PRONOUNCED DEAD C. HOUR _____ D. DATE SIGNED MONTH 2 DAY 5 YEAR 77											
C. LAST SEEN ALIVE MONTH 1 DAY 31 YEAR 77												E. NAME OF CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER											
D. NAME OF ATTENDING PHYSICIAN, IF OTHER THAN CERTIFIER																							
24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, CORONER, MEDICAL EXAMINER, CORONER'S PHYSICIAN, MEDICAL DIRECTOR): Joseph P. Armenia 5811 South Park Ave, Hamburg, N.Y. 14075																							
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) <i>Multiple Pulmonary emboli</i> DUE TO, OR AS A CONSEQUENCE OF:												Days											
(B) <i>Rt. Subclavian artery femoral fracture</i> DUE TO, OR AS A CONSEQUENCE OF:												1 mo.											
(C)																							
PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART 1 (A) <i>Chronic atherosclerotic heart disease; severe emphysema</i>												26A AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 26B IF YES, WERE FINDINGS CONSIDERED IN DETERMINING THE CAUSE OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
27A SPECIFY IF ACCIDENT, HOMICIDE, SUICIDE, UNDETERMINED, PENDING INVESTIGATION.												27B DATE OF INJURY MONTH 1 DAY 31 YEAR 77											
27C HOUR OF INJURY												27D DESCRIBE HOW INJURY OCCURRED.											
27E INJURY AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>												27F PLACE OF INJURY: HOME, FACTORY, OFFICE BLDG., ETC.											
27G LOCATION (STREET & NO., CITY OR VILLAGE, TOWN, COUNTY, STATE)																							