

PLACE OF DEATH

# RECORD OF DEATH

Registrar's No. \_\_\_\_\_

County Crowns  
 Township \_\_\_\_\_  
 City or Borough Port Jervis  
 Name of Hospital or Institution \_\_\_\_\_  
 (If not in hospital or institution write street number or location)  
 Length of stay in this Community \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days \_\_\_\_\_ hrs.

FORMER OR USUAL RESIDENCE  
 State Ind County \_\_\_\_\_  
 City or Borough Churchtown  
 (If outside city or borough limits, name township.)  
 Street No. \_\_\_\_\_  
 (If rural give location)  
 If foreign born, how long in U.S.A? \_\_\_\_\_ years

Kindly Print or Type

FULL NAME  
 (Surname last)  
 (First name here)  
Joseph Offer

If veteran, name war No Social Security No. 214-16-6341  
 SEX Male COLOR OR RACE Col Single, Married, Widowed or Divorced (write the word) Single  
 If married, widowed or divorced \_\_\_\_\_ Age, if living \_\_\_\_\_  
 HUSBAND OF (Give full maiden name) \_\_\_\_\_  
 (or) WIFE OF \_\_\_\_\_

BIRTH DATE OF DECEASED (Month, day and year) Feb 1907  
 AGE Years 46 Months \_\_\_\_\_ Days \_\_\_\_\_  
 If Less Than One Day \_\_\_\_\_ Hrs. \_\_\_\_\_ Min. \_\_\_\_\_

BIRTHPLACE (City or town) Ind  
 (State or country)

Usual occupation \_\_\_\_\_  
 Industry or business Carter

NAME Char Offer  
 BIRTHPLACE (City or town) \_\_\_\_\_  
 (State or country)  
 MAIDEN NAME Ella Thurston  
 BIRTHPLACE (City or town) \_\_\_\_\_  
 (State or country)

SIGNATURE OF INFORMANT Floyd Offer  
 (Address) \_\_\_\_\_

PLACE OF BURIAL (Name of cemetery or removal) Tamona

DATE OF BURIAL Jan 3-1-1953 Churchtown Ind  
 N. J. License No. \_\_\_\_\_

TOWNSHIP DIRECTOR Thomas Thompson  
 (Address) Edwards St

RECEIVED -22, 1953 W. R. Clark  
 Local Registrar.

## MEDICAL CERTIFICATION

DATE OF DEATH Dec 18 1952

I HEREBY CERTIFY, That I attended the deceased from 11:15 A.M. to 2-27 1953  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_ and that death occurred on the date stated above, at Churchtown, Ind.

Immediate cause of death Accidental Poisoning  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

PHYSICIAN  
 \_\_\_\_\_  
 Underlines the cause to which death should be charged anatomically.

If death were due to external causes, fill in the following:

Accident, suicide, or homicide (specify) Accident

Date of occurrence Dec 18-1952

Where did injury occur? Corner of Ave J & J  
 (City or town) (County) (State)

Did injury occur in or about home, on farm, in industrial place, in public place? City of Port  
 (Specify type of place)

While at work? No Means of injury \_\_\_\_\_

Signature Jean Louise Shannon  
 (M.D. or other)  
 Address 11111 E. 2-27-53  
 Date signed