

Death Certificate for Harry J. Meleski

Son of Joseph Meleski & Katherine Warchol

REVERSE SIDE		The Commonwealth of Massachusetts				REGISTERED NUMBER	STATE USE ONLY		
		STANDARD CERTIFICATE OF DEATH				107	16980		
		REGISTRY OF VITAL RECORDS AND STATISTICS							
DECEDENT	1 DECEDENT - NAME FIRST MIDDLE LAST		2 SEX		3 DATE OF DEATH (Mo., Day, Yr.)				
	4a PLACE OF DEATH (CITY OR TOWN)		4b COUNTY OF DEATH		4c HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)		4d IF IN HOSPIT. D.O.A. (Yes or No)		
	5 RACE - (e.g. White, Black, American Indian, etc.) (Specify)	6a AGE - Last Birthday (Yrs)	6b UNDER 1 YEAR MOS	6c UNDER 1 DAY HOURS MINS	7 DATE OF BIRTH (Mo., Day, Yr.)	8 STATE OF BIRTH (If not in U.S.A., name country)			
	9 MARRIED, NEVER MARRIED, WIDOWED OR DIVORCED	10 SPOUSE (If wife, give maiden name)		11a USUAL OCCUPATION (Prof. - If Retired)		11b KIND OF BUSINESS OR INDUSTRY			
12 SOCIAL SECURITY NUMBER		13 IF U.S. WAR VETERAN SPECIFY WAR	14 RESIDENCE - STREET AND NUMBER, CITY OR TOWN, COUNTY, STATE, ZIP CODE						
15a FATHER - FULL NAME		15b STATE OF BIRTH (If not in U.S.A., name country)	16a MOTHER NAME (GIVEN) MAIDEN		16b STATE OF BIRTH (If not in U.S.A., name country)				
17a INFORMANT - NAME AND ADDRESS		17b RELATIONSHIP							
DISPOSITION	18a TYPE OF DISPOSITION (Specify Burial, Cremation, Other)		18b DATE OF DISPOSITION	18c PLACE OF DISPOSITION AND LOCATION		18d CITY OR TOWN STATE			
	19a FUNERAL SERVICE LICENSEE		19b NAME OF FACILITY		19c ADDRESS OF FACILITY				
	20 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) (PRINT OR TYPE LEGIBLY)								
CAUSE OF DEATH	PART I					Interval between onset and death			
	(a) RESPIRATORY FAILURE					IMMEDIATE			
	(b) ASPIRATION PNEUMONIA - (Secondary)					WEEKS			
	(c) PARKINSON'S SYNDROME					Interval between onset and death			
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in Part I (a)					21 AUTOPSY (Yes or No)				
BENIGN PROSTATIC HYPERTROPHY					22 WAS CASE REFERRED TO MED EXAM (Yes or No)				
23 ACC SUICIDE, HOM UNDET OR PENDING INVEST (Specify)		24a DATE OF INJURY (Mo., Day, Yr.)	24b HOUR OF INJURY	24c DESCRIBE HOW INJURY OCCURRED					
23		24a	24b	24c					
24d INJURY AT WORK (Specify Yes or No)		24e PLACE OF INJURY - At home, farm, street, factory, office building, etc (Specify)		24f LOCATION STREET		24g CITY OR TOWN STATE			
CERTIFIER	25a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated			26a On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated					
	(Signature and Title) <i>Leonard Morse, MD</i>			(Signature and Title) <i>Robert J. O'Keefe</i>					
	25b DATE SIGNED (Mo., Day, Yr.)		25c HOUR OF DEATH		26b DATE SIGNED (Mo., Day, Yr.)		26c HOUR OF DEATH		
	25b Jan 8, 1981		25c 0920		26b		26c		
	25d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			26d ON		26e PRONOUNCED DEAD (Mo., Day, Yr.)		26f PRONOUNCED DEAD (Hour)	
	25d			26d ON		26e AT		26f M	
27 NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print)									
LEONARD MORSE, MD 200 LINCOLN ST WORCESTER, MA. 01605									
28 I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued				29 RECEIVED AND FILED IN THE CITY OR TOWN OF					
(SIGNATURE - BD. HEALTH AGT.) <i>Charles J. ...</i>				WORCESTER JAN 14 1981					
DATE ISSUED 1/11/81				(CLEAN SIGNATURE) <i>Robert J. O'Keefe</i>					
				(DATE RECEIVED)					