

# Death Record for Jean B. Danko

## Daughter of Alexander Skowronski & Frances Dymek

The Commonwealth of Massachusetts STANDARD CERTIFICATE OF DEATH REGISTRY OF VITAL RECORDS AND STATISTICS		96 2517 ✓	048586
DECEDENT - NAME FIRST MIDDLE LAST 1 Jean B. Danko		SEX 2 F	DATE OF DEATH (Mo., Day, Yr.) 3 October 18, 1996
PLACE OF DEATH (City/Town) 4a Worcester		COUNTY OF DEATH 4b Worcester	HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number) 4c Memorial Health Care
PLACE OF DEATH (Check only one): HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		SOCIAL SECURITY NUMBER 6 017-09-7098	IF US WAR VETERAN SPECIFY WAR 7 - - -
WAS DECEDENT OF HISPANIC ORIGIN? (Yes, Specify Puerto Rican, Dominican, Cuban, etc.) 8a NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		RACE (e.g. White, Black, American Indian, etc.) (Specify): 8b White	DECEDENT'S EDUCATION (Highest Grade Completed) Elem/Sec (0-12)   College (1-4, 5+) 9 12   -
AGE - Last Birthday (Yrs.) 10a 79	UNDER 1 YEAR MOS   DAYS b	UNDER 1 DAY HOURS   MINS c	DATE OF BIRTH (Mo., Day, Yr.) 10d March 31, 1917
BIRTHPLACE (City and State or Foreign Country) 11 Worcester, Massachusetts		MARRIED, NEVER MARRIED, WIDOWED OR DIVORCED 12 Widowed	LAST SPOUSE (If wife, give maiden name) 13 Michael J. Danko, Jr.
USUAL OCCUPATION (Prior - if retired) 14a Housewife		KIND OF BUSINESS OR INDUSTRY 14b At home	
RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY 15a 157 Burbank Rd., Sutton, Worcester, County, Massachusetts			ZIP CODE 15b 01590
FATHER - FULL NAME 16 Alexander F. Skowronski		STATE OF BIRTH (If not in US, name country) 17 Poland	MOTHER - NAME (GIVEN) (MAIDEN) 18 Frances Dymek
STATE OF BIRTH (If not in US, name country) 19 Poland		INFORMANT'S NAME 20 James M. Danko	
MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE 21 3 Garden St., Grafton, MA 01519		RELATIONSHIP 22 Son	
METHOD OF DISPOSITION <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> DONATION <input type="checkbox"/> OTH. SPEC.		FUNERAL SERVICE LICENSEE 24 Henry V. Karolkiewicz	
LICENSE # 25 4555		PLACE OF DISPOSITION (Name of Cemetery, Crematory or other) 26a Notre Dame Cemetery	
LOCATION (City/Town, State) 26b Worcester, Massachusetts		DATE OF DISPOSITION (Mo., Day, Yr.) 27 Oct. 22, 1996	
NAME AND ADDRESS OF FACILITY 28a/b Henry Funeral Service, 33 Ward St., Worcester, MA 01610		PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d). PRINT OR TYPE LEGIBLY. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Sepsis b. Respiratory failure - status - c. post lung volume reduction surgery 3 months d. Chronic obstructive pulmonary disease years Approximate Interval Between Onset and Death 9 days	
PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.		WAS AUTOPSY PERFORMED? (Yes or No) 31 NO	
WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) 32 NO		WAS CASE REFERRED TO M.E.? (Yes or No) 33 NO	
MANNER OF DEATH 34 NATURAL <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> COULD NOT BE DETERMINED <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/>		DATE OF INJURY (Mo., Day, Yr.) 35a	
TIME OF INJURY 35b		INJURY AT WORK (Yes or No) 35c	
DESCRIBE HOW INJURY OCCURRED 35d		PLACE OF INJURY - At home, farm, street, factory, office bldg., etc. Specify 35e	
LOCATION (No. & St., City/Town, State) 35f		To be Completed by CERTIFYING PHYSICIAN Only 36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated (Signature and Title) Svetlana MIRONOV, M.D.	
DATE SIGNED (Mo., Day, Yr.) 36b October 18, 1996		HOUR OF DEATH 36c 5:30 P.M.	
NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER 36d S. Said MD.		To be Completed by MEDICAL EXAMINER 37a 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)	
NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print) 38 Svetlana MIRONOV 119 Belmont St Worcester MA 01605		DATE SIGNED (Mo., Day, Yr.) 37b	
HOUR OF DEATH 37c		PRONOUNCED DEAD (Mo., Day, Yr.) 37d	
PRONOUNCED DEAD (Hr.) 37e		LICENSE NO. OF CERTIFIER 39 96-4177-99	
WAS THERE AN R.N. PRONOUNCED? (Yes or No) 40a NO		IF YES, DATE PRONOUNCED 40b	
IF YES, TIME PRONOUNCED 40c		NAME OF PRONOUNCING REGISTERED NURSE 40d	
DATE BURIAL PERMIT ISSUED October 21, 1996		RECEIVED IN THE CITY/TOWN/COUNTY WORCESTER	
SIGNATURE - BO OF HEALTH AGENT Commissioner of Public Health		DATE OF RECORD OCT 21, 1996	

# Death Record for Jean B. Danko

## Daughter of Alexander Skowronski & Frances Dymek

The Commonwealth of Massachusetts STANDARD CERTIFICATE OF DEATH REGISTRY OF VITAL RECORDS AND STATISTICS				96 2517 REGISTERED NUMBER		048586 STATE USE ONLY		
DECEDENT - NAME			FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (Mo., Day, Yr.)	
1			Jean	B.	Danko	2 F	3 October 18, 1996	
PLACE OF DEATH (CITY OR TOWN)		COUNTY OF DEATH		HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)				
4a Worcester		4b Worcester		4c Memorial Health Care				
PLACE OF DEATH (Check only one): HOSPITAL:			OTHER:			SOCIAL SECURITY NUMBER	IF US WAR VETERAN SPECIFY WAR	
5 X Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/>			6 <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			6 017-09-7098	7 - -	
WAS DECEDENT OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.) X NO <input type="checkbox"/> YES <input type="checkbox"/>			RACE - (e.g., White, Black, American Indian, etc.) (Specify)			DECEDENT'S EDUCATION Elem/Sec (0-12)	(Highest Grade Completed) College (1-4, 5+)	
8a. Specify:			8b White			9 12		
AGE - Last Birthday (Yrs.)	UNDER 1 YEAR	UNDER 1 DAY		DATE OF BIRTH (Mo., Day, Yr.)		BIRTHPLACE (City and State or Foreign Country)		
10a 79	MOS. : DAYS	HOURS : MINS.		10b March 31, 1917		11 Worcester, Massachusetts		
MARRIED, NEVER MARRIED, WIDOWED OR DIVORCED		LAST SPOUSE (If wife, give maiden name)			USUAL OCCUPATION (Prior - If Retired)		KIND OF BUSINESS OR INDUSTRY	
12 Widowed		13 Michael J. Danko, Jr.			14a Housewife		14b At home	
RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY						ZIP CODE		
15a 157 Burbank Rd., Sutton, Worcester County, Massachusetts						15b 01590		
FATHER - FULL NAME		STATE OF BIRTH (If not in US, name country)		MOTHER - NAME (GIVEN) MAIDEN		STATE OF BIRTH (if not in US, name country)		
16 Alexander F. Skowronski		17 Poland		18 Frances Dymek		19 Poland		
INFORMANT'S NAME				MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE			RELATIONSHIP	
20 James M. Danko				21 3 Garden St., Grafton, MA 01519			22 Son	
METHOD OF DISPOSITION			FUNERAL SERVICE LICENSEE			LICENSE #		
23 X BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> <input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> <input type="checkbox"/> DONATION <input type="checkbox"/> OTH. SPEC:			24 Henry V. Karolkiewicz			25 4555		
PLACE OF DISPOSITION (Name of Cemetery, Crematory or other)				LOCATION (City/Town, State)				
26a Notre Dame Cemetery				26b Worcester, Massachusetts				
DATE OF DISPOSITION (Mo., Day, Yr.)		NAME AND ADDRESS OF FACILITY						
27 Oct. 22, 1996		28a/b Henry Funeral Service, 33 Ward St., Worcester, MA 01610						
29 PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d). PRINT OR TYPE LEGIBLY.						Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death)						9 days		
a. Sepsis								
b. Respiratory failure - status -								
c. post lung volume reduction surgery						3 months		
d. Chronic obstructive pulmonary disease						years		
30 PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.						31. NO	32. NO	
33 WAS CASE REFERRED TO M.E.? (Yes or No)		34 MANNER OF DEATH			DATE OF INJURY (Mo., Day, Yr.)	TIME OF INJURY	INJURY AT WORK (Yes or No)	
NO		X NATURAL <input type="checkbox"/> HOMICIDE <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> COULD NOT BE DETERMINED <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/>			35a	35b	35c	
To be completed by CERTIFYING PHYSICIAN Only	36a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) [signed] Svetlana MIRONOV, M.D.				To be Completed by MEDICAL EXAMINER Only	37a. 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)		
	DATE SIGNED (Mo., Day, Yr.)		HOUR OF DEATH			DATE SIGNED (Mo., Day, Yr.)		HOUR OF DEATH
	36b October 18, 1996		36c 5:30 PM			37b		37c M
	36d NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER S. Saïd MD.					37d. PRONOUNCED DEAD (Mo., Day, Yr.)		37e. PRONOUNCED DEAD (Hour)
NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print)						LICENSE NO. OF CERTIFIER		
38 Svetlana MIRONOV 119 Belmont St Worcester MA 01605						39 96-4177-99		
40a WAS THERE AN R.N. PRONOUNCEMENT? (Yes or No)		40b IF YES, DATE PRONOUNCED	40c IF YES, TIME PRONOUNCED		40d NAME OF PRONOUNCING REGISTERED NURSE			
NO			M		NAME			
DATE BURIAL PERMIT ISSUED				RECEIVED IN THE CITY/TOWN OF:			DATE OF RECORD	
October 21 1996				WORCESTER			43 OCT 21, 1996	
SIGNATURE - BD OF HEALTH AGENT		[signed] Arnold Gurwitz MD Commissioner of Public Health			CLERK'S SIGNATURE		[signed] Robert J. O'Keefe	
41					42			