



DEPARTMENT OF

Health & Rehabilitative Services

DISTRICT ELEVEN

I HEREBY CERTIFY THIS TO BE A TRUE
COPY OF THE LOCAL REGISTRAR'S RECORD
OF DEATH.

DADE COUNTY DEPARTMENT OF
PUBLIC HEALTH

1350 N. W. 14TH ST.
MIAMI, FLORIDA 33125

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WARNING:

(Not valid unless the raised seal
of the Bureau of Vital Statistics
is affixed.)

Beatrice Marchetti
DEPUTY REGISTRAR

13373

CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO.		13373					
DECEDENT—NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (Mo., Day, Yr.)	
1		Beatrice	E.	O'Halloran	2 Female	3 September 20, 1986	
RACE—e.g., White, Black, Am. Indian, etc. (Specify)	AGE—Last Birthday (Yrs.)	UNDER 1 YEAR	UNDER 1 DAY	DATE OF BIRTH (Mo., Day, Yr.)	COUNTY OF DEATH		
4 White	5a 87	MOS. 5b	DAYS 5c	HOURS 5d	MINS. 5e	6 May 13, 1899	7a Dade
CITY, TOWN OR LOCATION OF DEATH		HOSPITAL OR OTHER INSTITUTION—Name (if not in either, give street and number)			IF HOSP. OR INST. (Indicate DOA, OP/Emer. Rm., Inpatient (Specify))		
7b North Miami		7c Fountainhead Nursing Home			7d Inpatient		
STATE OF BIRTH (If not in U.S.A., name country)	CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	SURVIVING SPOUSE (If wife, give maiden name)				
8 New York	9 U.S.A.	10 Widowed	11 None				
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY			
12 112 26 6106		13a Nurse		13b Nursing			
RESIDENCE—STATE	COUNTY	CITY, TOWN OR LOCATION		STREET AND NUMBER	INSIDE CITY LIMITS (Specify Yes or No)		
14a Florida	14b Dade	14c North Miami Beach		14d 515 NE 179 DR.	14e Yes		
FATHER—NAME		FIRST	MIDDLE	LAST	MOTHER—MAIDEN NAME		
15		John		Hogan	16 Sarah Craft		
INFORMANT—NAME (Type or Print)		MAILING ADDRESS					
17a Edward O'Halloran		17b 19305 NE 2nd Ave N. Miami Bch. FL 33179					
BURIAL, CREMATION, REMOVAL OTHER (Specify)	CEMETERY OR CREMATORY—NAME		LOCATION	CITY OR TOWN	STATE		
18a Removal	18b St. Mary's Cemetery		18c	Yonkers	New York		
FUNERAL DIRECTOR—(Signature)		FUNERAL HOME ADDRESS					
19a		19b Lithgow Funeral Center 15011 W. Dixie Highway N Miami, FL 33181					
20a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) ▶ <i>Walter J. DeMaio M.D.</i>		20b. DATE SIGNED (Mo., Day, Yr.) 9/22/86		20c. HOUR OF DEATH 10:00 ^A			
20d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		20e. To be Completed by MEDICAL EXAMINER					
20d		21a. 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) ▶		21b. DATE SIGNED (Mo., Day, Yr.)			
20d		21a		21c. HOUR OF DEATH			
20d		21a		21d. PRONOUNCED DEAD (Mo., Day, Yr.)			
20d		21a		21e. PRONOUNCED DEAD (Hour)			
20d		21a		21f. ON			
20d		21a		21g. AT			
NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or print)							
22. Walter J. DeMaio M.D. 1295 NW 14th Street, Miami, Fla. 33167							
REGISTRAR				DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)			
23a (Signature) ▶ <i>Ronald L. Lawrence</i>				23b. SEP 24 1986			
24. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))							
PART I	(a)	Cerebral Hemorrhage				Interval between onset and death	
DUE TO, OR AS A CONSEQUENCE OF, (Condition(s) which gave rise to cause (a) — List underlying cause last)							
PART I	(b)	Cerebral Dura				Interval between onset and death	
DUE TO, OR AS A CONSEQUENCE OF:							
PART I	(c)	Atherosclerotic Cerebral Dura				Interval between onset and death	
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)							
PART III IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			AUTOPSY (yes or no) 25 NO		CASE REFERRED TO MEDICAL EXAMINER (Specify Yes or No) 26 NO		
(Probably) ACCIDENT, SUICIDE or HOMICIDE, or UNDETERMINED (Specify)		DATE OF INJURY (Mo., Day, Yr.)	HOUR OF INJURY	DESCRIBE HOW INJURY OCCURRED			
27a		27b	27c	27d			
INJURY AT WORK (Specify Yes or No)		PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	LOCATION	STREET OR R.F.D. NO.	CITY OR TOWN	STATE	
27e		27f	27g				

TYPE OR PRINT
PERMANENT
BLACK INK
SEE
HANDBOOK
FOR
INSTRUCTIONS

7a

7b 6324

7c

7d

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12

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17a

17b

18a

19a

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