DEPARTMENT OF HEALTH
BOROUGH OF RICHMOND

Certificate of Death

Certificate No. 1504

FILED
1947 AUG 1 AM 11 10

1. NAME OF DECEASED (Print or Typewrite): Andrew (First Name) Fabiszak (Middle Name) Unknown (Last Name) Social Security Number

PERSONAL PARTICULARS
(To be filled in by Funeral Director)

2 USUAL RESIDENCE: (a) State New York
(b) Co. Richmond (c) Post Office and Zone Staten Isl.
(d) No. 597 Rensselaer Ave. Ave. St.
(If in rural area, give location)
(e) Length of residence or stay in City of New York immediately prior to death 19 Yrs

3 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

4 WIFE / HUSBAND of Margaret Fabiszak

5 DATE OF BIRTH OF DECEDENT: (Month) October (Day) 13 (Year) 1893

6 AGE: 53 yrs. 9 mos. 17 days. If LESS than 1 day, hrs. or min.

7 Occupation
A Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Chauffeur
B Industry or business in which work was done, as silk mill, sawmill, bank, own business, etc. Dept of Sanat.

8 BIRTHPLACE OF DECEDENT: (a) State New York (b) County (c) City, Town or Village Brooklyn

9 OF WHAT COUNTRY WAS DECEDENT A CITIZEN AT TIME OF DEATH? United States

10 WAS DECEASED WAR VETERAN? IF SO, NAME WAR World War #1

PARENTS OF DECEASED
11 NAME OF FATHER OF DECEDENT: JOHN
12 BIRTHPLACE OF FATHER (State or country): POLAND
13 MAIDEN NAME OF MOTHER OF DECEDENT: CATHERINE GRECHOWIAK
14 BIRTHPLACE OF MOTHER (State or country): POLAND

MEDICAL CERTIFICATE OF DEATH
(To be filled in by the Physician)

16 PLACE OF DEATH:
(a) NEW YORK CITY: (b) Borough Richmond
(c) Name of Hospital or Institution Halloran VA Hospital Staten Island 2, N.Y.
(If not in hospital or institution, give street and number)
(d) If in hospital, give Ward No. 2A1
(e) Length of stay at place of death immediately prior to death 5 Days

17 DATE AND HOUR OF DEATH: (Month) July (Day) 30 (Year) 1947 (Hour) 8:25 P. M.

18 SEX: Male | 19 COLOR OR RACE: White | 20 Approximate Age: 53 Yrs

21 I HEREBY CERTIFY that (I attended the deceased)* (a staff physician of this institution attended the deceased)*
from July 26 1947, to July 30 1947,
and last saw him alive at 8:25 P.M. on July 30 1947.

I further certify that death † was not caused, directly or indirectly by accident, homicide, suicide, acute or chronic poisoning, or in any suspicious or unusual manner, and that it was due to NATURAL CAUSES more fully described in the confidential medical report filed with the Department of Health.

* *Cross out words that do not apply.*
† *See first instruction on reverse of certificate.*

Witness my hand this 31st day of July 1947.

Signature [signature] M. D.
Halloran VA Hospital
Address Staten Island 2, New York

15 SIGNATURE OF INFORMANT: Halloran VA Hospital | RELATIONSHIP TO DECEASED | ADDRESS: Staten Island 2, N.Y.

22 PLACE OF BURIAL OR CREMATION: St Marys Cemetery | DATE OF BURIAL OR CREMATION: Aug 4th 1947

23 FUNERAL DIRECTOR: Walter B Cooke Inc | ADDRESS 571 Forest Ave | PERMIT NUMBER 3252

BUREAU OF RECORDS AND STATISTICS — DEPARTMENT OF HEALTH — CITY OF NEW YORK

1147
5 P.C.
8/1/47
M.N.

R8646
1 P.C.
8/6/47
V.N.

R1417
2 P.C.
8/24/47
V.N.

PHYSICIAN'S CONFIDENTIAL MEDICAL REPORT

This report is based on: (autopsy) (operation) (laboratory tests) (clinical findings)
(Cross out terms which do not apply)

	Date of Onset
Principal cause: Cerebral Thrombosis	
Contributory causes	
Other pathological conditions	

Autopsy—Date of: None *(If none, so state)* Operation—Date of: *(If none, so state)*

Type of operation: Condition for which performed:

Laboratory tests that assisted diagnosis, if any:

Any history of pregnancy in last 6 months? If so, date of delivery:

Signature: [signature] M.D.

Address: Halloran VA Hospital Staten Island 2, New York

Position*—~~Attending physician~~ ~~(Superintendent)~~ ~~(Chief of Medical Service)~~ (Resident physician) ~~(Interne)~~ ~~(Pathologist)~~

* *Cross out terms which do not apply*

†CAUTION TO PHYSICIANS: **BEFORE SIGNING, READ THIS ENTIRE STATEMENT CAREFULLY.**

The physician will personally complete the certification on the face of the certificate by inserting the words "was not" in the space provided in the second paragraph of Item 21, if the resultant statement would be true. If, after the insertion of these words, the resultant statement would NOT be true, the case must be referred to the Office of the Chief Medical Examiner.

FAILURE TO REPORT TO THE MEDICAL EXAMINER IS A MISDEMEANOR.

FUNERAL DIRECTOR'S CERTIFICATE

I hereby certify that I have been employed, without any solicitation on my part or that of any other person, to dispose of the remains of Andryo Fabisak by Margaret Fabisak of 597 Rensselaer Ave S.I. #12 who is the Wife (Relationship) and the nearest surviving relative or next of kin of the deceased.

This statement is made to obtain a permit for the burial or cremation of the remains of the deceased.

Name of permittee: Walter B Cooke Inc Permit No. 32052

By: Robert Hamilton 3007
(Signature of licensed manager or funeral director if other than permittee.)

To Be Filled In by the Funeral Director When Obtaining Removal Permit by Telephone

Telephone Removal No. 5 granted by: Miss Costello (Burial Clerk)

Date: 31/July/47 Hour: 3:45 (A. M.) (P. M.) Walter B. Cooke, Inc. (Funeral Director) John H. Reco

Deaths that are even remotely associated with an earlier accident, must be referred to the Medical Examiner.