

1st Great Grand Brother

The Health Department of the City of New York

HAS MADE THE FOLLOWING ORDER:

"All Permits for the removal of the body of any deceased person from the City of New York for Interment, and all Burial Permits, and Permits for the Disinterment of the remains of deceased persons in the City of New York, shall be granted and signed by the Register of Records."

The Physician who attended any person in a last illness is responsible for the presentation of this Certificate, accurately filled out, to the BUREAU OF VITAL STATISTICS, with a 24 HOURS after said person's death. (Sec. 161 of Sanitary Code.)

NO PERMIT FOR BURIAL CAN BE OBTAINED WITHOUT A PROPER CERTIFICATE.

All physicians practicing in New York City (including those in public institutions) are required to register with the Bureau of Vital Statistics. (Sec. 16 of Sanitary Code.)

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CERTIFICATE OF DEATH

1. First Name of Deceased, *Edward Good Child*
Write legibly and a full name. If an infant, give sex and name.

2. Age, *72* years, *5* months, *10* days, Color, *W*

3. Single, Married, Widowed, *Married*

4. Birthplace, *Ireland* (How long in the United States, if of foreign birth.)

5. How long resident in this city, *47* years

6. Father's Birthplace, *Ireland*

7. Mother's Birthplace, *Ireland*

8. Place of Death, (If no number, give street No.) *21 Hamilton*

72 yrs 5mo
 Born Ireland
 Father } Ireland
 Mother }
 31 Hamilton St

9. If a Dwelling, by how many families, living separately, occupied, *15* Floor, *2nd* Ward, *7*

10. If Sundry Causes, that I attended deceased from *May 10* 1881 to *May 10* 1881 that I last saw *deceased* on the *10* day of *May* 1881 that he died on the *10* day of *May* 1881, about *10* o'clock *A.M.* (that the Cause of death was:)

Time from Attack till Death, *10* hours

First (Primary), *Pneumonia*

Second (Immediate), *Asphyxia*

1881
 May 10th

ALL the above information should be filed and by the Physician.

Place of Burial, *Young City Cemetery*

Date of Burial, *May 12th 1881*

Undertaker, *Francis A. ...*

Place of Residence, *21 Hamilton St*

Signature, *W. P. ...* M.D.

Address, *W. P. ...*