



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS  
CERTIFICATE OF DEATH

File No. **111651**  
Registered No. **23414**

Primary Dist. No. **5101-461**

29

2-39B

1. PLACE OF DEATH a. County <b>Phila</b>		2. USUAL RESIDENCE (where deceased lived. If institution: residence before admission) a. State <b>Penn</b> b. County <b>Phila</b>	
b. City, Borough or Township <b>Phila</b>		c. City, Borough or Township <b>Phila</b>	
c. Length of stay in lb. <b>34 yrs</b>		d. Street Address or Location <b>2443 So. Lawrence St</b>	
d. FULL NAME (If NOT in hospital, give street address) of HOSPITAL or INSTITUTION <b>AEMC - Southern</b>		e. Is Residence Inside Municipality Limits? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. Is Place of Death Inside Municipality Limits? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		f. Is Residence on a Farm? Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) a. (First) <b>Fred</b> b. (Middle) <b>Komisar</b> c. (Last) <b>Komisar</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>12 15 56</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1891</b>	9. AGE (in years last birthday) <b>65</b>	If under 1 year: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10. FULL NAME OF SPOUSE <b>Sarah Komisar</b>			11. BIRTHPLACE (Also give state or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>Bouch</b>			14. MOTHER'S MAIDEN NAME <b>Pessie</b>		
15. USUAL OCCUPATION (even if retired) <b>Shoemaker</b>		16. Social Security No.	17. INFORMANT ADDRESS <b>Sarah Komisar 2443 S Lawrence St</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) & (c)] PART I. Death was caused by:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>+ Cerebral vascular accident</b>		<b>4 days</b>
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b) <b>+ Cerebral arteriosclerosis</b>		<b>years</b>
DUE TO (c) <b>+ .</b>		<b>331X</b>
PART II. OTHER SIGNIFICANT CONDITIONS [contributing to death but not related to the terminal disease given in Part I (a)]		19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>None</b>	20b. DESCRIBE HOW INJURY OCCURRED.	20c. Time of Injury Hour, m. E.S.T. Month, Day, Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., home, farm, factory, street, etc.)	20f. CITY, BOROUGH, TOWNSHIP COUNTY STATE

21. I hereby certify that I attended the deceased from **12/5** to **12/15**, 19**56**, that I last saw the deceased alive on **12/15**, 19**56**, and that death occurred at **10:40 PM**, E.S.T., from the causes and on the date stated above.

22a. SIGNATURE <b>Ignacio Comore</b> M.D. or D.O.	22b. ADDRESS <b>AEMC - Southern</b>	22c. DATE SIGNED <b>12/15/56</b>
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23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>	23b. DATE <b>12-17-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Not Lebanon Cem</b>	23d. LOCATION (City, Boro., Twp. & County) (State) <b>Collingdale Del Pa</b>
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24. DATE REC'D BY REG. <b>DEC 17 1956</b>	25. REGISTRAR'S SIGNATURE <b>Joseph G. Farrell</b>	26. SIGNATURE OF FUNERAL DIRECTOR <b>Jacob Goldstein</b> ADDRESS <b>2129 N. Broad St</b>
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