

CERTIFICATE OF DEATH

CLASS NO.

NO. OF RECORD

36780

CENSUS TRACT NO.

DISTRICT OF COLUMBIA HEALTH DEPARTMENT, BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH: *Indian Head Md* 2. USUAL RESIDENCE OF DECEASED:
 (a) Street address *Indian Head Md* (a) State *Md* (b) County _____
 (b) Name of hospital or institution _____ (c) City or town *Indian Head*
 (If outside city or town limits write RURAL)
 (c) Length of stay: In hospital or institution _____ (d) Street address _____
 (If rural give location)
 (d) In District of Columbia _____ (e) If foreign born, how long in U. S. A.? _____ years

3. (a) FULL NAME (Print) *JOSEPH HILTON REGAN*

3. (b) SOCIAL SECURITY NO. _____

3. (c) IF VETERAN, NAME WAR _____

4. SEX: *Male* 5. COLOR OF HAIR: *White* 6. (a) SINGLE, MARRIED, WIDOWED, DIVORCED: *Single*

6. (b) NAME OF HUSBAND OR WIFE _____

7. BIRTH DATE OF DECEASED *Feb. 12 - 1897*
(Month) (Day) (Year)

8. AGE: *65* Years Months Days If LESS than one day _____ hr. _____ min.

9. BIRTHPLACE *Washington D.C.*
(City, town or county) (State or foreign country)

10. USUAL OCCUPATION *Veteran*

11. INDUSTRY OR BUSINESS _____

Father { 12. NAME (Print) *Timothy H. Regan*
13. BIRTHPLACE *Ireland*
(City, town, or county) (State or foreign country)

Mother { 14. MAIDEN NAME *Susan Gibson*
15. BIRTHPLACE *Pa.*
(City, town, or county) (State or foreign country)

16. (a) INFORMANT *Miss Doris Goodman*

(b) ADDRESS *1604 No. Rhodes St. N.W.*

(c) RELATION OF INFORMANT TO DECEDENT *Nephew*

17. (a) PLACE OF BURIAL, CREMATION, OR REMOVAL *Congressional*

(b) DATE *9-15-42*
(Month) (Day) (Year)

18. (a) *W.W. Chambers Co*
(Signature of funeral director)

(b) ADDRESS *577 U.S. St. S.E.*

MEDICAL CERTIFICATION

20. DATE OF DEATH: *9-13-42*
(Month) (Day) 19*42*

at _____ m.
(State exact time of death)

21. I HEREBY CERTIFY that I attended the deceased from _____, 19____, to _____, 19____;

That I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death *Chronic Bronchitis* IERATION

Due to *Cardiac Failure*

Due to _____

Other conditions _____

(Include report of pregnancy within 3 months of death)

OPERATION: _____

Name _____ Date _____

Major findings _____

Autopsy findings _____

If death was due to external causes, fill in the following:

(a) Nature of injury _____ (specify)

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, in industrial place, in public place? _____ (Specify type of place)

(e) Means of injury _____

23. SIGNATURE *Clay Price Reg.*

Address *Indian Head Md* signed *9/13/42*

IMPORTANT NOTICE.—Failure to submit a Certificate of Death to the Health Department within forty-eight hours after the date of death is a violation of the laws of the District of Columbia. It is also a violation for any person or persons having custody of a body to hold it unburied for a longer period than one week after death. Violation of these laws is punishable by fine or imprisonment or both.

THIS IS A PERMANENT RECORD. PLEASE FILL OUT WITH TYPEWRITER (EXCEPT SIGNATURES) OR WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY; if unknown, give approximate age. PHYSICIANS should state CAUSE of DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. Space for remarks may be found on the other side.