

MARGIN RESERVED FOR BLENDING
 WRITE PLAINLY WITH UNFADING INK - THIS IS A PERMANENT RECORD
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Form No. 5232 Master St.

CERTIFICATE OF DEATH

COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

Registration District No. 57

Primary Registration District No. 57

File No. 1179

Registered No. 147

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

1. PLACE OF DEATH
 County of Philadelphia
 Township of Philadelphia
 or Borough of Philadelphia
 or City of Philadelphia

2. FULL NAME: Mannah O'Brien McGran

(a) Residence, No. 5232 Master St. St. 34 Ward 44
 (Usual Place of Abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred: 14 yrs. mos. da. How long in U. S., if of foreign birth 34 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

6. If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh O'Brien McGran

7. DATE OF BIRTH (month, day and year) July 12th 1865

7. AGE Years 69 Months 5 Days 22 IF LESS than 1 day hrs. — min. —

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home
 (b) General nature of industry, business or establishment in which employed, (or employer) —
 (c) Name of employer —

9. BIRTHPLACE (city or town) (State or Country) Liffersary Ireland

10. NAME OF FATHER John O'Brien

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Julia Toohy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant (Address) Charles A. McGran 5232 Master St.

15. Filed JAN 4 - 1935 19 1935 Registrar J. W. ...

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 3 (Day) 1935 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/30/34 19 to 1/3/35 19 that I last saw him alive on 11/3/35 19 and that death occurred, on the date stated above, at 4:30 P.M. The CAUSE OF DEATH was as follows: Cerebral Hemorrhage

826 (duration) yrs. mos. 5 days

CONTRIBUTORY (Secondary) — (duration) yrs. mos. days

18. Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings
 (Signed) Walter J. ... M.D.
1/3/35 19 (Address) 1400 O'Connell St.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL St. Ann's Cemetery Jan 7th 1935

20. UNDERTAKER Charles J. Weber 3635 Spring Garden St. ADDRESS

(OVER)