

CERTIFICATE OF DEATH
STATE OF CONNECTICUT DEPT. OF HEALTH SERVICES

DECEASED - NAME aka FIRST MIDDLE LAST Marian (Marion) K. Condos		SEX F	STATE FILE NUMBER
DATE OF BIRTH (Month, Day, Year) March 16, 1925	RACE - White, Negro, American Indian, etc. (specify) White	AGE - Last Birthday (Years) 60	DATE OF DEATH (Month, Day, Year) Feb. 23, 1986
COUNTY OF DEATH Fairfield	TOWN OF DEATH Stamford	HOSPITAL OR OTHER INSTITUTION - Name (if not in either, give street and number) St. Joseph Medical Center	
CITY & STATE OF BIRTH (Country, if not U.S.) Stamford, CT.	CITIZEN OF (Country) U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, LEGALLY SEPARATED Married	LAST SPOUSE (if wife, give maiden name) Speros Condos
SOCIAL SECURITY NUMBER 046-14-6647	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal Secretary	KIND OF BUSINESS OR INDUSTRY Attys. Curtis, Brinkerhoff & Barrett	
RESIDENCE - STATE CT.	COUNTY Fairfield	TOWN Stamford	STREET AND NUMBER 82 Crystal St.
WAS DECEASED A VETERAN? (Specify yes or no) NO	IF YES, GIVE WAR ----	UNIT OR SHIP ----	
FATHER - NAME FIRST MIDDLE LAST Martin J. Killeen	MOTHER - MAIDEN NAME FIRST MIDDLE LAST Nora Fahey		
INFORMANT - NAME Mr. Speros Condos - Husband			
MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip) 82 Crystal St. Stamford, CT. 06902			
PART I. DEATH WAS CAUSED BY (Enter Only One Cause Per Line For (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myoplama			5 years
CONDITIONS, IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST DUE TO, OR AS A CONSEQUENCE OF:			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to death but not related to cause given in Part I (a)			AUTOPSY (Yes/No) No
IF YES were findings considered in determining cause of death			
CERTIFICATION - PHYSICIAN I attended the deceased from Month Day Year 1-8-86	And Last Saw Him/Her Alive on Month Day Year 2-23-86	DEATH OCCURRED (Hour) 8:40 AM	ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.
WAS CASE REFERRED TO MEDICAL EXAMINER (Specify Yes or No) No	SURGERY RELEVANT TO CONDITION REPORTED IN ITEM 28 (Name of Operation) (Date performed) 2-23-86	THE DECEDENT WAS PRONOUNCED DEAD MONTH DAY YEAR 2-23-86	
CERTIFIER - NAME (Type or print) Victoria GRANN	SIGNATURE <i>[Signature]</i>	Degree or Title	
MAILING ADDRESS - CERTIFIER Street or R.F.D. No., City or Town, State, Zip 140 Hoyt St - Stamford, CT. 06902			
DATE SIGNED (Month, Day, Year) 2/23/86			
BURIAL, CREMATION, REMOVAL (Specify) Burial	CEMETERY OR CREMATORY - NAME Woodland Cemetery	LOCATION City or Town, State Stamford, CT.	
DATE (Month, Day, Year) Feb. 25, 1986	FUNERAL HOME - NAME AND ADDRESS (Street or R.F.D. No., City or Town, State, Zip) P.O. Box 1301 06904 Bosak Funeral Home Inc. 641 Atlantic St. Stamford, CT.		
FUNERAL DIRECTOR OR EMBALMER - SIGNATURE <i>[Signature]</i>	NAME OF EMBALMER if body was embalmed Paul M. Deary	LICENSE NUMBER 1881	
THIS CERTIFICATE RECEIVED FOR RECORD ON FEB 24 1986	BY <i>[Signature]</i>	REGISTRAR	

I hereby certify that the foregoing is a true copy of the record on file in the Office of Stamford Town Clerk, attested by the Raised Seal of the City of Stamford, CT.

[Signature]
Assistant Registrar

Legal Fee: \$10.00

THIS CERTIFICATE IS NOT VALID WITHOUT THE RAISED SEAL

July 10, 2008

