

1 PLACE OF DEATH

STATE OF NEW YORK

25-2469-13-24, Form 10 21

BOROUGH OF Manhattan

Department of Health of The City of New York
BUREAU OF RECORDS

STANDARD CERTIFICATE OF DEATH

Name of Institution Springfield Hospital

Register No. 25815

2 FULL NAME Thomas R. Tierney

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write above) Single

15 DATE OF DEATH September 13th 1919
(Month) (Day) (Year)

6 DATE OF BIRTH September 13, 1919
(Month) (Day) (Year)

7 AGE 7 yrs. 7 mos. 11 ds. or 30 min.
If LESS than 1 day, hrs.

16 I hereby certify that the foregoing particulars (Nos. 1 to 15 inclusive) are correct as near as the same can be ascertained, and I further certify that deceased was admitted to this institution on September 13th 1919 that I last saw him alive on the 13th day of September 1919 that he died on the 13th day of September 1919, about 7:00 o'clock A. M. or P. M., and that I am unable to state definitely the cause of death; the diagnosis during his last illness was: Excephalocoele

8 OCCUPATION (a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

duration yrs. mos. 4 1/2 yrs.

9 BIRTHPLACE (State or country) U. S. A.

Contributory (Secondary) duration yrs. mos. ds.

(A) How long in U. S. (if of foreign birth) Life (B) How long resident in City of New York Life

Witness my hand this 13 day of Sept 1919.
Signature W. H. Kessler M.D.
House

10 NAME OF FATHER Frank Tierney

17 I hereby certify that I have this ___ day of ___ 19___, performed an autopsy upon the body of said deceased, and that the cause of his death was as follows:

11 BIRTHPLACE OF FATHER (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER May Barry

13 BIRTHPLACE OF MOTHER (State or country) U. S. A.

14 Special INFORMATION required in deaths in hospitals and institutions and in deaths of non-residents and recent residents.

Former or usual residence

Signature _____ M. D.

Where was disease contracted, if not at place of death?

Pathologist _____ Hospital _____

FILED SEP 15 1919

18 PLACE OF BURIAL Holy Cross Cemetery

DATE OF BURIAL Sept 16 1919

19 UNDERTAKER A. D. Graham

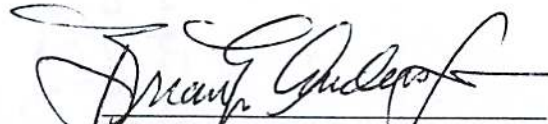
ADDRESS 1886 Lexington Ave

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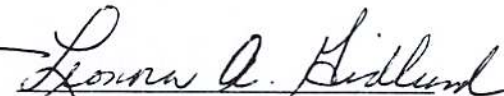
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Brian G. Andersson
Commissioner, Department of Records



Leonora A. Gidlund
Director, Municipal Archives