STATE OF NEW YORK

Department of Health of The City of New York

BUREAU OF RECORDS

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH

BOROUGH OF Manhattan

Name of Institution Lying-in 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 which): Single

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

7 AGE: — yrs. — mos. — ds. If LESS than 1 day, 4 hrs. or 30 min.

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

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

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

PARENTS OF DECEASED

10 NAME OF FATHER: Frank Tierney

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

12 MAIDEN NAME OF MOTHER: Mary Berry

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

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

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

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 h[illegible] 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 h[illegible] last illness was: Encephalocele

duration — yrs. — mos. 4½ hrs. ds.

Contributory (Secondary)

duration — yrs. — mos. — ds.

Witness my hand this 13th day of Sept. 1919.

Signature [illegible] M.D.

House [illegible]

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 h— death was as follows:

Signature — M. D.

Pathologist — Hospital

MARGIN RESERVED FOR BINDING
NO MUTILATED CERTIFICATE WILL BE RECEIVED

FILED SEP 15 1919

18 PLACE OF BURIAL: Holy Cross Cemetery

DATE OF BURIAL: Sept 16, 1919

19 UNDERTAKER: H. D. Graham

ADDRESS: 1886 Lexington Ave

NEW YORK CITY DEPARTMENT OF RECORDS AND INFORMATION SERVICES
MUNICIPAL ARCHIVES
31 Chambers Street
New York, N.Y. 10007

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Brian G. Andersson
Commissioner, Department of Records

Leonora A. Gidlund
Director, Municipal Archives