

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—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.

V. S. No. 1.

1 PLACE OF DEATH

6684

STATE OF MARYLAND  
CERTIFICATE OF DEATH

County Kent

Registration Dist. No. 202

Village or City Chestertown (No. Queen 79) St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Oscar Crozier

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE Gold 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married  
(Write the word)

16 DATE OF DEATH May 1<sup>st</sup>, 1915  
(Month) (Day) (Year)

6 DATE OF BIRTH Don't know, 1847  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1910, to May 1<sup>st</sup>, 1915, that I last saw him alive on Apr 30, 1915, and that death occurred on the date stated above, at 5.55 P.M.

7 AGE 68 yrs. 09 mos. 09 ds. If LESS than 1 day, hrs. OR min. ?

The CAUSE OF DEATH \* was as follows:  
Cardiac asthma

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

Contributory Resuscitation  
Secondary Resuscitation  
(Duration) yrs. mos. ds.

9 BIRTHPLACE (State or country) Phila Pa.

(Signed) W.A. Surpin, M. O.  
May 11, 1915 (Address) Chestertown

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (State or country) " "

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Crozier  
(Address)

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

15 Filed May 8, 1915 W.S. Hicks REGISTRAR  
Todd

19 PLACE OF BURIAL OR REMOVAL Chestertown Md DATE OF BURIAL May 7, 1915  
20 UNDERTAKER Chas. L. Todd ADDRESS Chestertown