

# Certificate of Death

22279

FILED

Certificate No.

2 NAME OF DECEASED  
(Print or Type) **Benjamin**

**SLADE**

First Name

Middle Name

Last Name

Social Security Number

## PERSONAL PARTICULARS (To be filled in by Funeral Director)

2 USUAL RESIDENCE: (a) State **NEW YORK**  
(b) Co. **KINGS** (c) Post Office **Brooklyn**  
(d) No. **110 Keap St** Ave. St.  
(If in rural area, give location)  
(e) Length of residence or stay in City of New York immediately prior to death **LIFE N.Y.**

3 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **MARRIED**

4 WIFE-HUSBAND { of **Rose**

5 DATE OF BIRTH OF DECEDENT (Month) (Day) (Year)

6 AGE 61 yrs. mos. days hrs. or min. If LESS than 1 day,

7 Occupation  
A Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **CLERK**  
B Industry or business in which work was done, as silk mill, sawmill, bank, own business, etc.

8 BIRTHPLACE OF DECEDENT: (a) State **NEW YORK**  
(b) County **MANHATTAN** (c) City, Town or Village

9 OF WHAT COUNTRY WAS DECEDENT A CITIZEN AT TIME OF DEATH? **U.S.A.**

10 WAS DECEASED WAR VETERAN? IF SO, NAME WAR **no vet**

11 NAME OF FATHER OF DECEDENT **Simon -**

12 BIRTHPLACE OF FATHER (State or country) **Russia**

13 MAIDEN NAME OF MOTHER OF DECEDENT **Rachael Schenquist**

14 BIRTHPLACE OF MOTHER (State or country) **Russia**

15 SIGNATURE OF INFORMANT **Slade**

RELATIONSHIP TO DECEASED **Son**

ADDRESS **5423 Ft. Hamilton Pkwy Bklyn**

22 PLACE OF BURIAL OR CREMATION **Mt. Hebron Cemetery**

DATE OF BURIAL OR CREMATION **November 12, 1948**

23 FUNERAL DIRECTOR **Jeffer Funeral Home**

ADDRESS **45-28 11th St**

PERMIT NUMBER **3136**

BUREAU OF RECORDS AND STATISTICS

DEPARTMENT OF HEALTH

CITY OF NEW YORK

## MEDICAL CERTIFICATE OF DEATH (To be filled in by the Physician)

16 PLACE OF DEATH:

(a) NEW YORK CITY: (b) Borough **Brooklyn**  
(c) Name of Hospital or Institution **110 Keap Street**  
(If not in hospital or institution, give street and number.)

(d) If in hospital, give Ward No.

(e) Length of stay at place of death immediately prior to death **15 years**

17 DATE AND HOUR OF DEATH (Month) (Day) (Year) (Hour) **November 11 1948 5:30 P.M.**

18 SEX **Male** 19 COLOR OR RACE **White** 20 Approximate Age **61 years**

21 I HEREBY CERTIFY that (I attended the deceased)\*  
(a staff physician of this institution attended the deceased)\*  
from **17 February 1948** to **11 November 1948**,  
and last saw him alive at **5:15 P.M.** on **11 November 1948**.

I further certify that death **was not** caused, directly or indirectly by accident, homicide, suicide, acute or chronic poisoning, or in any suspicious or unusual manner, and that it was due to NATURAL CAUSES more fully described in the confidential medical report filed with the Department of Health.

\* Cross out words that do not apply.  
† See first instruction on reverse of certificate.

Witness my hand this **11** day of **November** 19 **48**

Signature **William Lypton** M. D.

Address **543 Bedford Ave Bklyn**

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BUREAU OF RECORDS  
DEPARTMENT OF HEALTH  
BOROUGH OF BROOKLYN

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**DO NOT WRITE IN THIS SPACE. RESERVED FOR HEALTH DEPARTMENT RECORDS.**

Deaths that are even remotely associated with an earlier accident, must be referred to the Medical Examiner.

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11-22-22

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