CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH
REGISTRY OF VITAL RECORDS AND STATISTICS

973200

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH
~~SUFFOLK~~ (County)
BOSTON (City or Town)
No. 54 Esmond St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

BOSTON 262 (City or town making return)
Registrar's No. 8398

2 FULL NAME Annie Prosofsky
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 54 Esmond St. Dorchester Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community 12 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: F	18 DATE OF DEATH: Sept. 30, 1945 (Month) (Day) (Year)
4 COLOR OR RACE: white	19 I HEREBY CERTIFY, That I attended deceased from Sept. 2/45 19 to Sept.30/45 19
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed	I last saw her alive on Sept. 28 1945, death is said to have occurred on the date stated above, at 11 AM M.
5a If married, widowed, or divorced HUSBAND of Julius Prosofsky (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)	Immediate cause of death: Broncho Pneumonia — Duration (IMPORTANT): 3 Days
6 Age of husband or wife if alive ... years	Cerebral arterio sclerosis — 2 Yrs
7 IF STILLBORN, enter that fact here.	Due to 107-97
8 AGE 83 Years Months Days; If less than 1 day Hours Minutes	Due to
9 Usual Occupation: Housewife	Other conditions (Include pregnancy within 3 months of death)
10 Industry or Business: At Home	Major findings: Of operations — Date of
11 Social Security No. None	Of autopsy
12 BIRTHPLACE (City) (State or country): Poland 20-7	What test confirmed diagnosis? Examination
13 NAME OF FATHER: Zelig Borofsky	IMPORTANT Physician Underline the cause to which death should be charged statistically.
14 BIRTHPLACE OF FATHER (City) (State or country): Poland 20-7	20 Was disease or injury in any way related to occupation of deceased? No. If so, specify
15 MAIDEN NAME OF MOTHER: Sarah -	(Signed) H Korb M. D. (Address) Boston Mass Date 9-30 1945
16 BIRTHPLACE OF MOTHER (City) (State or country): Poland 20-7	21 Place of Burial, Cremation or Removal: Tifareth Israel West Roxbury (City or Town)
17 Informant (Address): Dora Borofsky — Relation, if any: Daughter	DATE OF BURIAL Oct. 1/45 19
I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:	22 NAME OF FUNERAL DIRECTOR H Levine; ADDRESS Dorchester Mass.
(Signature of Agent of Board of Health or other)	Received and filed Oct. 3/45 19
(Official Designation) (Date of Issue of Permit)	A TRUE COPY ATTEST: Thomas F. [illegible] (Registrar)

VOID IF ALTERED OR ERASED

FEB 9 2012

Stanley E. Nyberg
Registrar of Vital Records and Statistics

I, the undersigned, hereby certify that I am the Registrar of Vital Records and Statistics; that as such I have custody of the records of birth, marriage, and death required by law to be kept in my office; and I do hereby certify that the above is a true copy from said records.

IT IS ILLEGAL TO ALTER OR REPRODUCE THIS DOCUMENT IN ANY MANNER

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED