1 PLACE OF DEATH

BOROUGH OF Manhattan

STATE OF NEW YORK

Department of Health of The City of New York

BUREAU OF RECORDS

STANDARD CERTIFICATE OF DEATH

Register No. 18456

Name of Institution St. Elizabeth Hospital

2 FULL NAME William Joseph Coogan

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH Nov 7, 1892 (Month) (Day) (Year)

7 AGE 30 yrs. 8 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.

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

9 BIRTHPLACE (State or country) N.Y.

(9)(A) How long in U.S. (if of foreign birth) Life

(9)(B) How long resident in City of New York Life

PARENTS OF DECEASED

10 NAME OF FATHER Patrick Coogan

11 BIRTHPLACE OF FATHER (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mary Mulhern

13 BIRTHPLACE OF MOTHER (State or country) N.Y.

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

Former or usual residence 852 [illegible] Place Bklyn

Where was disease contracted, if not at place of death 852 [illegible] Place Bklyn

MARGIN RESERVED FOR BINDING

NO MUTILATED CERTIFICATE WILL BE RECEIVED

15 DATE OF DEATH July 8, 1923 (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 July 1 1923, that I last saw him alive on the 8 day of July 1923, that he died on the 8 day of July 1923, about 8.35 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:

Duodenal Ulcer
(Gastroenterostomy)

duration 1 yrs. ... mos. ... ds.

Contributory (Secondary) Lobar Pneumonia

duration ... yrs. ... mos. 5 ds.

Witness my hand this 8 day of July 1923

Signature William [illegible] M.D.

House Visiting Surgeon

298 Lexington Ave.

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

FILED	18 PLACE OF BURIAL	DATE OF BURIAL
1923 JUL 9	Calvary Cem.	July 11, 1923
	19 UNDERTAKER Wm Murphy	ADDRESS 57 Herbert St

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