MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Form V. S. 12

5-22-39—40M.

Department of Commerce
Bureau of the Census

CERTIFICATE OF DEATH

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

State File No. 20439

Registered No. 18

1. PLACE OF DEATH
(a) County *Fairfax* Registration district No. 0291 1293 (For reg. use)
(b) Magisterial district
(c) City or town *Falls Church*
(d) Name of hospital or institution
(e) Length of stay in hosp. or inst. In this community *1 yr.* (Specify whether years, months, or days)
(f) Is place of death within corporate limits?

2. USUAL RESIDENCE OF DECEASED
(a) State *Virginia*
(b) County *Fairfax Co.*
(c) City or town *Falls Church*
(d) Street No. *335 - Little Falls St.*
(e) Is place of residence within corporate limits?
(f) If foreign birth, how long in U. S. A? Years

3. (a) FULL NAME *Minnie S. Avery*

3. (b) If veteran, name war *None*

4. Sex *F*
5. Color or race *White*
6. (a) Single, married, widowed, divorced. *Wid.*
6. (b) Name of husband or wife

7. Date of birth of deceased *May 5, 1873* (Month by name) (Day) (Year)

8. Age: Years *89? 69 (over)* Months Days If less than one day hours min.

9. Birthplace (City, town, or county) *Penn.* (State or foreign country)

10. Usual occupation *None*

11. Industry or business

Father
12. Name *George Schaeffer*
13. Birthplace (City, town, or county) *Penn.* (State or foreign country)

Mother
14. Maiden name *Susan Casidy*
15. Birthplace (City, town or county) *Penn.* (State or foreign country)

16. (a) Informant's own signature *Mr Robt. Avery*
(b) Address *Richmond, Va.*

17. (a) Burial, cremation, or removal? *Wash. D.C.*
(b) Place Date *Sept. 12 - 42* (Month by name) (Day) (Year)

18. (a) Signature of funeral director *J. William Lee's Sons*
(b) Address *300 - 4th St. N.E.*

19. (a) Filed *9/12 1942* (Date received by reg.) (b) *Macon Ware* (Local, deputy, or sub-registrar's own signature)

MEDICAL CERTIFICATION

20. Date of death *Sept* (Month by name) *11* (Day) 19*42* (Year) at *11 P.M* (Hour)

21. I hereby certify that I attended the deceased from *Sept 5* 19*42* to *Sept 11* 19*42*; that I last saw h*er* alive on *Sept 5* 19*42* and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death *Mitral Lesion of Heart*	*1922 Feb*
Due to *Chronic Severely malarial nephritis*	*10 yrs 1932*
Due to	
Other conditions (Include pregnancy within 3 months of death)	

131 B

Name of operation
Date of operation Major findings: (a) of operations
(b) of autopsy

Physician
Underline the primary cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature *John P. Greenwood* M. D., Cor., or other
Address *West Falls Church Va.* Date signed *9/12/42*