CITY OF CAMBRIDGE
MASSACHUSETTS 02139 · 617-876-6800

Barbara Ackermann
Mayor

Sir:

Notice is hereby given that a Special Meeting of the City Council will be held on Thursday, October 26th, 1972, at 7:30 p.m. in the auditorium of the Rindge Technical School for the following purpose:

To listen to requests of certain citizens groups.

By Order of Her Honor the Mayor

Barbara Ackermann

FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-5-71-049420

1 PLACE OF DEATH: ..... (County) ..... (City or Town)

The Commonwealth of Massachusetts
JOHN F. X. DAVOREN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

..... (City or Town making this return)

Registered No. .....

No. ..... St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ..... (First Name) (Middle Name) (Last Name)
(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) Permanent Residence. No. ..... St. ..... (City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH ..... (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

.....

.....

.....

.....

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... While at work? ..... (How did injury occur?)

Manner of Injury ..... (Specify type of place)

Nature of Injury .....

Was autopsy performed? .....

Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

..... (Print or Type Name)

(Address) ..... Date .....19.....

6 .....
Place of Burial or Cremation (City or Town)

DATE .....19.....

7 NAME OF FUNERAL DIRECTOR .....

ADDRESS .....

8 Informant .....

(Address) .....

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE..... Years ..... Months ..... Days | If under 24 hours .....Hours .....Minutes

14 Usual Occupation: .....
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No.

17 BIRTHPACE (City) .....
(State or country)

PARENTS

18 NAME OF FATHER

19 BIRTHPLACE OF FATHER (City) .....
(State or country)

20 MAIDEN NAME OF MOTHER

21 BIRTHPLACE OF MOTHER (City) .....
(State or country)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

.....
(Signature of Agent Board of Health or other)

(Official Designation) (Date of Issue of Permit)

Received and filed .....19.....

(Registrar)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

Medical Examiners will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile" "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

If the cause of death has not been determined at the time of the certification, item #4 should be noted "Undetermined — pending further investigation."

Immediately upon the completion of the investigation, a new form R-303 should be complete insofar as the medical portion is concerned (Items #1 through #6) signed and filed with the local clerk so that the original return may be completed by adding the cause of death to it.

FORM R-303

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The Commonwealth of Massachusetts
JOHN F. X. DAVOREN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. .....

(City or Town making this return) .....

1 PLACE OF DEATH: MIDDLESEX (County); CAMBRIDGE (City or Town)

No. en route to THE CAMBRIDGE HOSPITAL St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME LAWRENCE (First Name) (Middle Name) LARGEY (Last Name)
(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) Permanent Residence. No. 101 HAMPSHIRE St. CAMBRIDGE, MASS.
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER (Month) 22nd. (Day) 1972 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

INGESTION OF RAPID ACTING BARBITURATE AND ETHYL ALCOHOL (OVERDOSE)

5 Accident, suicide, or homicide (specify) PROBABLY ACCIDENTAL

Date and hour of injury [redacted] 10-22 19 72

IF ACCIDENTAL, was injury causally related to the death? YES

Where did Injury occur? CAMBRIDGE, MASS (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? PUBLIC PLACE While at work? NO
(How did injury occur?)

Manner of Injury INGESTION OF BARBITURATES AND ALCOHOL
(Specify type of place)

Nature of Injury POISONING BY BARBITURATES AND ALCOHOL

Was autopsy performed? YES

Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) Charles R. Robinson, M. D.
CHARLES R. ROBINSON (Print or Type Name)
(Address) 89 BEACON ST. SOMERVILLE, MASS. Date 10-26 1972

6 Place of Burial or Cremation (City or Town)

DATE ..... 19.....

7 NAME OF FUNERAL DIRECTOR .....

ADDRESS .....

8 Informant .....

(Address) .....

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word)

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 AGE..... Years .....Months ..... Days | If under 24 hours .....Hours .....Minutes

14 Usual Occupation: .....
(Kind of work done during most of working life)

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16 Social Security No.

17 BIRTHPACE (City) .....
(State or country)

PARENTS

18 NAME OF FATHER

19 BIRTHPLACE OF FATHER (City) .....
(State or country)

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21 BIRTHPLACE OF MOTHER (City) .....
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1 -The two officers in the arrest of Larry Largey on last Saturday night are presently on leave of absence without pay.

2 - The City Council has been advised by the Manager that he will tomorrow appoint a personal representative having no connection with the City Government , to conduct an investigation of the whole matter and make a report to him. He will promptly take action based on that report. The police department has been directed to cooperate fully with the manager's representative.

3 - To clear up any doubts about the conclusion of the State Medical Examiner as to the reasons for Largey's death, a new post mortem examination will be conducted by a doctor picked by the Largey family.

1020

Papers on the Special meeting held
October 26, 1972