CERTIFICATE OF DEATH

State File Number
08 026186

NAME OF DECEDENT
For use by physician or institution

Items 1-23c To Be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's, if any) (First, Middle, Last): (b)(3):CPSA S
2. SEX: Female
3. SOCIAL SECURITY NUMBER: [redacted]
4a. AGE-Last Birthday (Years):
4b. UNDER 1 YEAR: Months: 3; Days:
4c. UNDER 1 DAY: Hours:; Minutes:
5. DATE OF BIRTH (MM/DD/YYYY): 05/08/2008
6. BIRTHPLACE (City and State or Foreign Country): (b)(6)
7a. RESIDENCE-STATE: (b)(6)
7b. COUNTY:
7c. CITY OR TOWN: (b)(6)
7d. STREET AND NUMBER: (b)(6)
7e. APT. NO.:
7g. INSIDE CITY LIMITS? ☒ Yes ☐ No
8. EVER IN US ARMED FORCES? ☐ Yes ☒ No
9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☒ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If Wife, give name prior to first marriage)
11. FATHER'S NAME (First, Middle, Last): (b)(6)
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)
13a. INFORMANT'S NAME: (b)(6)
13b. RELATIONSHIP TO DECEDENT: Family Member
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): (b)(6)
14. PLACE OF DEATH (Check only one: see instructions)
IF DEATH OCCURRED IN HOSPITAL: ☒ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify)
15. FACILITY NAME (If not institution, give street and number): (b)(6)
16. CITY OR TOWN, STATE AND ZIP CODE: (b)(6)
17. COUNTY OF DEATH
18. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from state ☐ Other (Specify)
19. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place): (b)(6)
20. LOCATION-CITY, TOWN AND STATE: (b)(6)
21. NAME AND ADDRESS OF FUNERAL FACILITY: (b)(6)
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT: (b)(6) (Signature on File)
23. LICENSE NUMBER (Of Licensee): (b)(NC) (b)(6)
23a. EMBALMER (Signature)
23b. EMBALMER LICENSE NUMBER
23c. LICENSE NUMBER (Of Facil NC

Items 24-48 To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
24. DATE PRONOUNCED DEAD (MM/DD/YYYY): 08/17/2008
25. TIME PRONOUNCED DEAD: 11:04 AM
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)
27. LICENSE NUMBER
28. DATE SIGN y)
29. ACTUAL OR PRESUMED DATE OF DEATH (Spell Month): August 17, 2008
30. ACTUAL OR PRESUMED TIME OF DEATH: 11:04 AM
31. WAS CORO OR MEDICAL EXAMINER CO TED? ☒ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT al events cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter use on a line. additional lines if necessary.

		Approximate Interval Onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Positional Asphyxia	W75
	Due to (or as a conseq	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b.	
	Due to (or as a consequence of)	
	c.	
	Due to (or as a consequence of)	
	d.	
	Due to (or as a consequence of):	

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

33. WAS AN AUTOPSY PERFORMED? ☒ Yes ☐ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☒ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown
36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to one year before death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH: ☐ Natural ☐ Homicide ☒ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined
38. DATE OF INJURY (Spell Month): August
39. TIME OF INJURY:
40. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area): Decedent's Home
41. INJURY AT WORK? ☐ Yes ☒ No
42. LOCATION OF INJURY-State: (b)(6) City or Town: (b)(6) County: York
Street & Number: (b)(6) Apartment Number: Zip Code: (b)(6)
43. DESCRIBE HOW INJURY OCCURRED: Wedged Between Bumper Guard and Pillow
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)
45. CERTIFIER (Check only one)
☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing and Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☒ Coroner/Medical Examiner-On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Signature of certifier: (b)(6) (Signature on File)
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): (b)(6)
46a. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER
47. TITLE OF CERTIFIER: Coroner
48. LICENSE NUMBER
49. DATE CERTIFIED (MM/DD/YYYY): 09/02/2008
50. DATE RECEIVED BY REGISTRAR (MM/DD/YYYY): 09/04/2008

Items 51-55 To Be Completed By: Funeral Director

51. DECEDENT'S EDUCATION- Check the box that best describes the highest degree or level of school completed at the time of death.
☒ 8th grade or less
☐ 9th-12th grade; no diploma
☐ High school graduate or GED completed
☐ Some college credit, but no degree
☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
52. DECEDENT OF HISPANIC ORIGIN? (Check one or more if Decedent is Spanish/Hispanic/Latino/ Latina. Check "No" if decedent is not Spanish/Hispanic/Latino/Latina)
☒ No, not Spanish/Hispanic/Latino/Latina
☐ Yes, Mexican, Mexican American, Chicano/Chicana
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino/Latina (Specify)
☐ Unknown
53. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
☒ White
☐ Black or African American
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Native Hawaiian
☐ Other Asian (Specify)
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)
☐ Other (Specify)
☐ Unknown
54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE THE TERM "RETIRED"): Infant
55. KIND OF BUSINESS/INDUSTRY

Amendment Code
Amendment Number:
Date:
Clerk ID:
ITP NO. 498502
IEC 870 v. 2004

ABSTRACT

FOR ADMINISTRATIVE AND STATISTICAL USE ONLY