

COMMONWEALTH OF KENTUCKY

6327213

REGISTRAR OF VITAL STATISTICS CERTIFIED COPY



KENTUCKY CERTIFICATE OF DEATH

116 202113671

Case #: E202104030012

1a. DECEDENT'S LEGAL NAME (First, Middle, Last) (Include AKA's if any) JACKIE MAURICE MORTENSON		1b. IF FEMALE, DECEDENT'S LAST NAME PRIOR TO FIRST MARRIAGE N/A		2. SEX MALE	
3. ACTUAL OR PRESUMED DATE OF DEATH (Month/Day/Year) (Spell Month) April 01, 2021		4. SOCIAL SECURITY NUMBER 288-32-7895		5a. AGE - LAST BIRTHDAY (Years) Months Days 85	
5b. UNDER 1 YEAR Hours Minutes		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (MM/DD/YYYY) 01/22/1936	
8. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Dead on Arrival OTHER: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		9. FACILITY NAME (If not institution, give street and number) 3192 PEPPERHILL RD			
11. BIRTHPLACE (City and State or Foreign Country) PINE GROVE, WEST VIRGINIA		12. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Married but Separated <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		13. SURVIVING SPOUSE (If wife, give name prior to first marriage)	
14. DECEDENT'S USUAL OCCUPATION (Kind of work done during most of working life.) (Do not use retired) BROADCAST COMMUNICATIONS		15. KIND OF BUSINESS/INDUSTRY RADIO		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
17a. RESIDENCE - State KENTUCKY		17b. COUNTY FAYETTE		17c. CITY OR TOWN LEXINGTON	
17d. STREET AND NUMBER 3192 PEPPERHILL RD		17e. ZIP CODE 40502		17f. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
18. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death.) <input type="checkbox"/> 8th Grade or Less <input type="checkbox"/> 9th-12th Grade: No Diploma <input type="checkbox"/> High School Graduate or GED Completed <input type="checkbox"/> Some College Credit but No Degree <input type="checkbox"/> Associates Degree (e.g., AA, AS) <input checked="" type="checkbox"/> Bachelor's Degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's Degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)		19. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if the decedent is not Spanish/Hispanic/Latino.) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify)		20. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) <input type="checkbox"/> Other (Specify)	
21. FATHER'S NAME (First, Middle, Last) EDWIN MAURICE MORTENSON		22. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) MARIE ELLEN WALLER			
23a. INFORMANT'S NAME DION MORTENSON		23b. RELATIONSHIP TO DECEDENT SON		23c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 4390 CLEARWATER WAY APT 1608, LEXINGTON, KY 40515	
24. METHOD OF DISPOSITION (Check only one) <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		25. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) LEXINGTON CEMETERY		26. LOCATION - City, Town, and State LEXINGTON, KY	
27. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such) JOEY A TUCKER		DATE SIGNED (MM/DD/YYYY) 04/03/2021		28. KY LICENSE NUMBER (of licensee) 5833	
(Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.118		29. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY MILWARD FUNERAL DIRECTORS, INC. 159 N. BROADWAY LEXINGTON, KY 40507			
30. DATE PRONOUNCED DEAD (MM/DD/YYYY) 04/01/2021		31. ACTUAL OR PRESUMED TIME OF DEATH 2320		32. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
33. PART I. Enter the chain of events - diseases, injuries, or complications - that caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) - 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		CAUSE OF DEATH a. VASCULAR DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): b. CEREBRAL VASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death UNKNOWN YEAR(S) UNKNOWN YEAR(S)	
PART II. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part I.		34. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined			
35. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within past year	
36. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		40. TIME OF INJURY		41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
39. DATE OF INJURY (Month/Day/Year) (Spell Month)		42. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)		43. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)	
44. DESCRIBE HOW INJURY OCCURRED:		45. LOCATION OF INJURY (Street and Number, City or Town, State, Zip Code)			
46. TO BE COMPLETED BY CERTIFIER: To the best of my knowledge, death occurred at the time, date, and place, and due to cause(s) and manner stated.		47. DATE CERTIFIED (MM/DD/YYYY) 04/08/2021		48. LICENSE NUMBER 23610	
SIGNATURE NANNETTE BERNALES, MD (Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 and KRS 369.118		49. TITLE OF CERTIFIER PHYSICIAN			
50. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (ITEM 33) NANNETTE BERNALES BLUEGRASS HOSPICE CARE (LEXINGTON), 2312 ALEXANDRIA DR, LEXINGTON, KY 40504		51. REGISTRAR'S SIGNATURE <i>Christina S. Stewart</i>			
		52. DATE FILED (MM/DD/YYYY) 04/08/2021			

To Be Completed By: Funeral Director (Must Be Typed)

To Be Completed By: Medical Certifier

This is to certify that this is a true and correct copy of the certificate of birth, death, marriage or divorce of the person therein named, and that the original certificate is registered at the Kentucky Office of Vital Statistics under the file number shown.

DATE ISSUED 04/08/2021

FORM VS NO. 1-A
(REVISED 06/2015)

Christina S. Stewart
State Registrar



DOCUMENT CONTAINS A WATERMARK - HOLD UP TO LIGHT TO VIEW