

**NEW YORK STATE
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

STATE FILE NUMBER

RECORDED DISTRICT 101		REGISTER NUMBER 1678		1. NAME: FIRST A.		MIDDLE Brooks		LAST Brown		2. SEX: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>		3A. DATE OF DEATH: MONTH 08 DAY 30 YEAR 2013		3B. HOUR: 5:15 PM			
4A. PLACE OF DEATH: (Check one) HOSPITAL DOA <input type="checkbox"/> ER <input type="checkbox"/> HOSPITAL OUTPATIENT <input type="checkbox"/> HOSPITAL INPATIENT <input checked="" type="checkbox"/> NURSING HOME <input type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER (Specify): <input type="checkbox"/>		4B. IF FACILITY, DATE ADMITTED: MONTH 08 DAY 30 YEAR 2013		4C. NAME OF FACILITY: (If not facility, give address) Albany Medical Center Hospital		4D. LOCALITY: (Check one and specify) CITY <input checked="" type="checkbox"/> VILLAGE <input type="checkbox"/> TOWN <input type="checkbox"/> Albany		4E. COUNTY OF DEATH: Albany		4F. MEDICAL RECORD NO. 2327068		4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> Southwestern Vermont Medical Center, Bennington County, Bennington, Vermont		5. DATE OF BIRTH: MONTH 05 DAY 27 YEAR 1947		6A. AGE IN YEARS: 66 yrs.	
6B. IF UNDER 1 YEAR ENTER: months <input type="checkbox"/> days <input type="checkbox"/>		6C. IF UNDER 1 DAY ENTER: hours <input type="checkbox"/> minutes <input type="checkbox"/>		7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Dallas, Texas		7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:		8. SERVED IN U.S. ARMED FORCES? (Specify years) NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino: A <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino B <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano C <input type="checkbox"/> Yes, Puerto Rican D <input type="checkbox"/> Yes, Cuban E <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify)		10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be: A <input checked="" type="checkbox"/> White/Caucasian B <input type="checkbox"/> Black or African American C <input type="checkbox"/> Asian Indian D <input type="checkbox"/> Chinese E <input type="checkbox"/> Filipino F <input type="checkbox"/> Japanese G <input type="checkbox"/> Korean H <input type="checkbox"/> Vietnamese J <input type="checkbox"/> Native Hawaiian K <input type="checkbox"/> Guamanian or Chamorro M <input type="checkbox"/> Samoan N <input type="checkbox"/> American Indian or Alaska Native (specify) P <input type="checkbox"/> Other Asian (specify) R <input type="checkbox"/> Other Pacific Islander (specify) S <input type="checkbox"/> Other (specify)					
11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. 1 <input type="checkbox"/> < 8th grade 2 <input type="checkbox"/> 9th-12th grade; no diploma 3 <input type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input checked="" type="checkbox"/> Associate's degree 6 <input type="checkbox"/> Bachelor's degree 7 <input type="checkbox"/> Master's degree 8 <input type="checkbox"/> Doctorate/Professional degree		12. SOCIAL SECURITY NUMBER: 465-78-6351		13. MARITAL STATUS: NEVER MARRIED <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated. Melinda Bell		15A. USUAL OCCUPATION: (Do not enter retired) Engineer		15B. KIND OF BUSINESS OR INDUSTRY: Radio		15C. NAME AND LOCALITY OF COMPANY OR FIRM: WEQX Manchester, Vermont		16A. RESIDENCE: (State or Country if not USA) Vermont		16B. County or Region/Province if not USA: Bennington	
16C. LOCALITY: (Check one and specify) CITY <input type="checkbox"/> VILLAGE <input type="checkbox"/> TOWN <input checked="" type="checkbox"/> Manchester		16D. STREET AND NUMBER OF RESIDENCE: 486 Riverbend Drive		16E. ZIP CODE: 05255		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SPECIFY TOWN:		17. BIRTH NAME OF FATHER / PARENT: FIRST William MI K. LAST Brown		18. BIRTH NAME OF MOTHER / PARENT: FIRST Eleanor MI LAST Brooks		19A. NAME OF INFORMANT: Melinda Brown		19B. MAILING ADDRESS: (include zip code) 486 Riverbend Drive, Manchester Center, Vermont 05255			
20A. 1 <input type="checkbox"/> BURIAL 2 <input checked="" type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL 4 <input type="checkbox"/> HOLD MONTH 09 DAY 03 YEAR 2013		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Vermont Cremation Service		20C. LOCATION: (City or town and state) Bennington, Vermont		21A. NAME AND ADDRESS OF FUNERAL HOME: Brewster & Shea Funeral Service 34 Park Place, Manchester Center, Vermont, 05255		21B. REGISTRATION NUMBER: 023.001023		22A. NAME OF FUNERAL DIRECTOR: James Michael Smith		22B. SIGNATURE OF FUNERAL DIRECTOR: <i>James Michael Smith</i>		22C. REGISTRATION NUMBER: 13362			
23A. SIGNATURE OF REGISTRAR: <i>Denise C Kelley</i>		23B. DATE FILED: MONTH 09 DAY 02 YEAR 2013		23C. BURIAL OR REMOVAL PERMIT ISSUED BY: <i>Denise C Kelley</i>		23D. DATE ISSUED: MONTH 09 DAY 02 YEAR 2013		25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated Certifier's Name: Paul L. Marra License No.: 112 State St. Albany, NY 12207 Signature: <i>Paul L. Marra</i> Month 08 Day 31 Year 2013		25B. If certifier is not a physician, enter Coroner's Physician's name & title: Michael S. Kinica MD License No.: 222488 Signature: <i>Michael S. Kinica</i> Month 08 Day 31 Year 2013		25C. If certifier is not attending physician, enter Attending Physician's name & title: Address: 112 STATE ST. ALBANY, NY 12207		26A. Attending physician attended deceased: FROM Month 08 Day 30 Year 2013 TO Month 08 Day 30 Year 2013			
26B. Deceased last seen alive by attending physician: Month 08 Day 30 Year 2013		26C. Pronounced Dead ON 08 DAY 30 YEAR 2013 AT 5:15 PM		27. MANNER OF DEATH: NATURAL CAUSE <input type="checkbox"/> ACCIDENT <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED CIRCUMSTANCES <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/>		28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29A. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> REFUSED		29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29C. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		29D. TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN			
30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) PART I. IMMEDIATE CAUSE: (A) Cerebral edema, cerebral contusions (B) and large subdural hematoma (C) due to blunt force trauma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I: History of alcohol intoxication with anticoagulation with acute ethanol intoxication		31A. IF INJURY, DATE: MONTH 08 DAY 27 YEAR 2013		31B. PLACE OF INJURY: Residence		31C. INJURY AT WORK? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		31D. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013		31E. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013		31F. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013		31G. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013			
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 <input type="checkbox"/> Driver/Operator 2 <input type="checkbox"/> Passenger 3 <input type="checkbox"/> Pedestrian 4 <input type="checkbox"/> OTHER (specify)		32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		33A. IF FEMALE: 0 <input type="checkbox"/> Not pregnant within last year 1 <input type="checkbox"/> Pregnant at time of death 2 <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death 3 <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death 4 <input type="checkbox"/> Unknown if pregnant within past year		33B. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013		33C. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013		33D. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013		33E. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013		33F. DATE OF DELIVERY: MONTH 08 DAY 30 YEAR 2013			

For use by physician or investigator:
NAME OF DECEDENT: **A. Brooks Brown**
TIME OF DEATH: **5:15 PM**
DATE OF DEATH: **08/30/13**