

STATE OF TEXAS
CERTIFICATION OF VITAL RECORD

DEPARTMENT OF STATE HEALTH SERVICES
VITAL STATISTICS

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS

Aug 30 2023

STATE OF TEXAS

CERTIFICATE OF DEATH

STATE FILE NUMBER

142-23-146442

1. LEGAL NAME OF DECEASED (Include AKA's, if any) (First, Middle, Last) (Before Marriage) STEPHEN WAYNE WILLIAMS

2. DATE OF DEATH - ACTUAL OR PRESUMED (mm-dd-yyyy) AUGUST 7, 2023

3. SEX MALE

4. DATE OF BIRTH (mm-dd-yyyy) [REDACTED]

5. AGE-Last Birthday (Years) 68

IF UNDER 1 YR Mo Days

IF UNDER 1 DAY Hours Min

6. BIRTHPLACE (City & State or Foreign Country) EL PASO, TX

7. SOCIAL SECURITY NUMBER [REDACTED]

8. MARITAL STATUS AT TIME OF DEATH
 Married Widowed (but not remarried)
 Divorced (but not remarried) Never Married Unknown

9. SURVIVING SPOUSE'S NAME (If spouse, give name prior to first marriage) [REDACTED]

10a. RESIDENCE STREET ADDRESS [REDACTED]

10b. APT. NO. [REDACTED]

10c. CITY OR TOWN WACO

10d. COUNTY MCLENNAN

10e. STATE TEXAS

10f. ZIP CODE [REDACTED]

10g. INSIDE CITY LIMITS? Yes No

11. FATHER/PARENT 2 NAME PRIOR TO FIRST MARRIAGE [REDACTED]

12. MOTHER/PARENT 1 NAME PRIOR TO FIRST MARRIAGE [REDACTED]

13. PLACE OF DEATH (CHECK ONLY ONE)
 IF DEATH OCCURRED IN A HOSPITAL: Inpatient ER/Outpatient DOA
 IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: Hospice Facility Nursing Home Decedent's Home Other (Specify)

14. COUNTY OF DEATH EL PASO

15. CITY/TOWN, ZIP (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO) EL PASO, 79905

16. FACILITY NAME (If not Institution, give street address) UNIVERSITY MEDICAL CENTER OF EL PASO

17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED [REDACTED]

18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code) [REDACTED]

19. METHOD OF DISPOSITION
 Burial Cremation Donation
 Entombment Removal from state Mausoleum
 Other (Specify)

20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH ROBERT FALCON, BY ELECTRONIC SIGNATURE - 9207

21. Unknown
 Section _____
 Block _____
 Lot _____
 Space _____

22. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) CRAWFORD CEMETARY

23. LOCATION (City/Town, and State) CRAWFORD, TX

24. NAME OF FUNERAL FACILITY AFFORDABLE BURIAL & CREMATION SERVICE

25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) 2006 N.W.S. YOUNG DR. STE. 60, KILLEEN, TX 76543

26. CERTIFIER (Check only one)
 Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
 Medical Examiner/Justice of the Peace - 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.

27. SIGNATURE OF CERTIFIER PAISITH PIRYAWAT, BY ELECTRONIC SIGNATURE

28. DATE CERTIFIED (mm-dd-yyyy) AUGUST 8, 2023

29. LICENSE NUMBER L1698

30. TIME OF DEATH (Actual or presumed) [REDACTED]

31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) PAISITH PIRYAWAT 4800 ALBERTA AVE, EL PASO, TX 79905

32. TITLE OF CERTIFIER MD

33. PART 1. ENTER THE CHAIN OF EVENTS - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. [REDACTED] Due to (or as a consequence of): [REDACTED]

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): _____

34. WAS AN AUTOPSY PERFORMED? Yes No

35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? Yes No

36. MANNER OF DEATH
 Natural Accident Suicide Homicide Pending Investigation Could not be determined

37. DID TOBACCO USE CONTRIBUTE TO DEATH?
 Yes No Previously Probably Unknown

38. 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

39. IF TRANSPORTATION INJURY, SPECIFY:
 Driver/Operator Passenger Pedestrian Other (Specify)

40a. DATE OF INJURY (mm-dd-yyyy) _____

40b. TIME OF INJURY _____

40c. INJURY AT WORK? Yes No

40d. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) _____

40e. LOCATION (Street and Number, City, State, Zip Code) _____

40f. COUNTY OF INJURY _____

41. DESCRIBE HOW INJURY OCCURRED _____

42a. REGISTRAR FILE NO. 01004887

42b. DATE RECEIVED BY LOCAL REGISTRAR AUGUST 30, 2023

42c. REGISTRAR [Signature]

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS UNIT

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine up to \$10,000. (Health and Safety Code, Sec. 195.105)

VS-112 REV 1/2006

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JON

This is a true and correct copy of the record as registered in the State of Texas. Issued under the authority of Section 191.051, Health and Safety Code.

ISSUED Sep 12 2023

TARA DAS
STATE REGISTRAR

WARNING: THIS DOCUMENT HAS A DARK BLUE BORDER AND A COLORED BACKGROUND

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

