GEORGIA DEATH CERTIFICATE

State File Number **2016GA000053045**

1. DECEDENT'S LEGAL FULL NAME (First, Middle, Last) **CRAIG MORGAN BAKER**	1a. IF FEMALE, ENTER LAST NAME AT BIRTH	2. SEX **MALE**	2a. DATE OF DEATH (Mo., Day, Year) **ACTUAL DATE OF DEATH 09/11/2016**

3. SOCIAL SECURITY NUMBER **161-36-6250**	4a. AGE (Years) **71**	4b. UNDER 1 YEAR Mos. / Days	4c. UNDER 1 DAY Hours / Mins.	5. DATE OF BIRTH (Mo., Day, Year) **07/06/1945**	

6. BIRTHPLACE **PENNSYLVANIA**	7a. RESIDENCE - STATE **GEORGIA**	7b. COUNTY **PUTNAM**	7c. CITY, TOWN **EATONTON**

7d. STREET AND NUMBER **869 W CHURCH STREET**	7e. ZIP CODE **31024**	7f. INSIDE CITY LIMITS? **UNKNOWN**	8. ARMED FORCES? **NO**

8a USUAL OCCUPATION **OWNER OPERATOR**	8b. KIND OF INDUSTRY OR BUSINESS **RADIO STATION**

9. MARITAL STATUS **MARRIED**	10. SPOUSE NAME **DEBRA MCDOUGLAD**	11. FATHER'S FULL NAME (First, Middle, Last) **MELVIN HERVEY BAKER**

12. MOTHER'S MAIDEN NAME (First, Middle, Last) **CONSTANCE KANE**	13a. INFORMANT'S NAME (First, Middle, Last) **DEBRA MCDOUGALD BAKER**	13b. RELATIONSHIP TO DECEDENT **WIFE**

13c. MAILING ADDRESS **869 W CHURCH STREET EATONTON GEORGIA 31024**	14. DECEDENT'S EDUCATION **HIGH SCHOOL GRADUATE OR GED COMPLETED**

15. ORIGIN OF DECEDENT (Italian, Mex.,French, English, etc.) **NO, NOT SPANISH/HISPANIC/LATINO**	16. DECEDENT'S RACE (White, Black, American Indian, etc.) (Specify) **WHITE**
17a. IF DEATH OCCURRED IN HOSPITAL	17b. IF DEATH OCCURRED OTHER THAN HOSPITAL (Specify) **HOSPICE FACILITY**

18. HOSPITAL OR OTHER INSTITUTION NAME (If not in either give street and no.) **GENTIVA HOSPICE AT ATHENS REGIONAL MEDICAL CENTER**	19. CITY, TOWN or LOCATION OF DEATH **ATHENS**	20. COUNTY OF DEATH **CLARKE**

21. METHOD OF DISPOSITION (specify) **CREMATION**	22. PLACE OF DISPOSITION **WILLIAMS CREMATORY 1670 NORTH JEFFERSON STREET GEORGIA 31061**	23. DISPOSITION DATE (Mo., Day, Year) **09/12/2016**

24a. EMBALMER'S NAME	24b. EMBALMER LICENSE NO.	25. FUNERAL HOME NAME **WILLIAMS FUNERAL HOME OF EATONTON**

25a. FUNERAL HOME ADDRESS
306 N JEFFERSON AVE EATONTON GEORGIA 31024

26a. SIGNATURE OF FUNERAL DIRECTOR **ARNETT HOLLIS HARRISON**	26b. FUN. DIR. LICENSE NO **4427**	AMENDMENTS

27. DATE PRONOUNCED DEAD (Mo., Day, Year) **09/11/2016**	28. HOUR PRONOUNCED DEAD **08:55 AM**		
29a. PRONOUNCER'S NAME **Carol Dianne Melson Wallace**		29b. LICENSE NUMBER **RN057619**	29c. DATE SIGNED **09/11/2016**

30. TIME OF DEATH **08:55 AM**	31. WAS CASE REFERRED TO MEDICAL EXAMINER **NO**

32. Part I. Enter the chain of events-diseases, injuries, or complicattons that directly caused the death DO NOT enter terminal events such as cardiac arrest, respiratory arrest, Of venticular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Approximate Interval between onset and death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	A. **SEPSIS WITH MULTI ORGAN SYSTEM FAILURES - RENAL, RESPIRATORY**	**OVER 4 DAYS**
	Due to, or as a consequence of B. **HEPATORENAL SYNDROME**	**4 DAYS**
	Due to, or as a consequence of C. **HEPATOCELLULAR CARCINOMA**	**MONTH**
	Due to, or as a consequence of D.	

Part II. Enter significant conditions contributing to death but not related to cause given in Part 1A. *If female, indicate if pregnant or birth occurred within 90 days of death.*	33. WAS AUTOPSY PERFORMED? **NO**	34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?

35. TOBACCO USE CONTRIBUTED TO DEATH **NO**	36. IF FEMALE (range 10-54) PREGNANT **NOT APPLICABLE**	37. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify) **NATURAL**

38. DATE OF INJURY (Mo., Day, Year)	39. TIME OF INJURY	40. PLACE OF INJURY (Horne, Farm, Street, Factory, Office, Etc.) (Specify)	41. INJURY AT WORK? (Yes or No)

42. LOCATION OF INJURY *(Street, Apartment Number, City or Town, State, Zip, County)*

43. DESCRIBE HOW INJURY OCCURRED	44. IF TRANSPORTATION INJURY

45. To the best of my knowledge death occurred at the time, date and place and due to the cause(s) stated. Medical Certifier (Name, Title, License No.) **JAMES L BROWN, MD, 21652**	46. 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) stated. Medical Examiner/Coroner (Name, Title, License No.)

45a. DATE SIGNED (Mo., Day, Year) **09/13/2016**	45b. HOUR OF DEATH **08:55 AM**	46a. DATE SIGNED (Mo., Day, Year)	46b. HOUR OF DEATH

47. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH
JAMES L BROWN 2090 PRINCE AVENUE ATHENS GEORGIA

48.REGISTRAR (Signature) **/S/ DONNA L. MOORE**	49. DATE FILED - REGISTRAR (Mo., Day, Year) **09/14/2016**