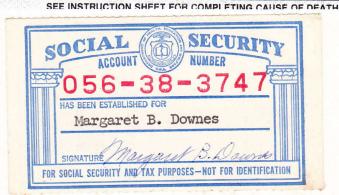
**NEW YORK STATE** STATE FILE NUMBER DEPARTMENT OF HEALTH CERTIFICATE OF DEATH MIDDLE 3A. DATE OF DEATH: MONTH 2. SEX: 13B. HOUR FEMALE 2 DAY YEAR MALE JUNE 3 90 10:4 MARGARET-B. OUNES HOSPITAL INPATIENT HOSPITAL OUTPATIENT NURSING HOME 4B. IF FACILITY, DATE ADMITTED: OTHER (Specify) 3 4C. NAME OF FACILITY: (If not facility give address) 4D. LOCALITY: (Check one and specify) 4E. COUNTY OF DEATH CITY OF VILLAGE OF 59RHCUSA ONON HOSP. UNIVERSIT 4F. MEDICAL RECORD NO: 14G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) YES 5. DATE OF BIRTH: 6. AGE: IF UNDER 1 YEAR I IF UNDER 1 DAY 1 7A. CITY AND STATE OF BIRTH: (Country | 17B. IF AGE UNDER 1 YEAR, NAME OF if not U.S.A.) minutes 5 YRACUS 9 N-Y-8. SERVED IN U.S. ARMED FORCES? (Specify years) 9. RACE: (Black, White, etc.) 11. EDUCATION: (Check only one) NO YES YES 13-15 12. SOCIAL SECURITY NUMBER: 13. MARITAL STATUS: NEVER MARRIED OR MARRIED SEPARATED WIDOWED 14. SURVIVING SPOUSE: (If wife, provide maiden name) DIVORCED ∃
3 1 2 3 4 15B. KIND OF BUSINESS OR INDUSTRY: DOWNES SYRACUSE SCHOOL SYRACUSE NOW NOT THE WAY STEM 15A. USUAL OCCUPATION: (Do not enter retired) EACHER SCHOOL 16B. COUNTY: 16C. LOCALITY: (Check one and specify) 16F. IF CITY OR VILLAGE IS TOWN OF CITY OF VILLAGE OF ONON. ONONDAGA RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES NO IF NO. SPECIFY TOWN: 16E. ZIP CODE: 13215 18. MAIDEN NAME FIRST LAST OSEPH HERBERT EMMA 19A. NAME OF INFORMANT 19B. MAILING ADDRESS (Include zip code) 13215 4954 MAWR 20B. PLACE OF BURIAL, CREMATION, REMOVAL OR DAY YEAR DISPOSITION: (Specify) 6 90 21B. REGISTRATION NUMBER: 9 50. 00766 22B. SIGNATURE OF FUNERAL DIRECTOR 22C. REGISTRATION NUMBER: AA. BURIAL OR REMOVAL PERMIT ISSUED BY: 23A SIGNATURE OF 23B. DATE MONTH 24B. DATE ISSUED: daler Line 6 90 ITEMS 25 THROUGH 33 TO BE ITEMS 20 THROUGH 33 TO BE - OR -COMPLETED BY CERTIFYING PHYSICIAN COMPLETED BY CORONER OR MEDICAL EXAMINER 25A. ON THE BASIS OF INVESTIGATION AND SUCH EXAMINATIONS CORONER AS I FELT NECESSARY, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED. SIGNATURE AND TITLE: 25B. THE PHYSICIAN ATTENDED THE DECEASED MEDICAL EXAMINER 3 90 6 25C. LAST SEEN ALIVE: 25B. PRONOUNCED DEAD 25C, HOUR: 25D. DATE SIGNED: MONTH DAY YEAR MONTH DAY MONTH DAY YEAR MONTH DAY - TO mi 25D. NAME OF ATTENDING PHYSICIAN; DR. THOMAS COYLE LICENSE NUMBER 25E. SIGNATURE OF CORONER OR CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER: 156633 26. NAME AND ADDRESS OF CERTIFIER: 25E ME/COR PHYS



PENDING

INVESTIGATION

6

28. WAS CASE REFERRED TO

CORONER OR MEDICAL EXAMINER?

O NO I YES

LICENSE NUMBER

29A. AUTOPSY? 29B. IF YES, WERE FINDINGS USED NO YES TO DETERMINE CAUSE OF DEATH?

SUNY HEALTH SCIENCE CNTR. 750 E. ADAMS ST. SYRACUSE, NY 13210

SUICIDE

UNDETERMINED

5

CIRCUMSTANCES

27. MANNER OF DEATH:

NATURAL CAUSE ACCIDENT HOMICIDE

2

CONFIDENTIAL