

OFFICE of VITAL STATISTICS
CERTIFIED COPY
FLORIDA CERTIFICATE OF DEATH

TYPE IN
PERMANENT
BLACK INK

LOCAL FILE NO.

1. DECEDENT'S NAME (First, Middle, Last, Suffix) Margery Dallet McIntire		2. SEX Female	
3. DATE OF BIRTH (Month, Day, Year) October 2, 1910		5. DATE OF DEATH (Month, Day, Year) May 30, 2008	
4a. AGE Last Birthday (Years) 97		4c. UNDER 1 YEAR Months: _____ Days: _____ Hours: _____ Minutes: _____	
6. SOCIAL SECURITY NUMBER 053-18-6728		8. COUNTY OF DEATH Saint Johns	
7. BIRTHPLACE (City and State or Foreign Country) Woodmere, LI, New York			
9. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival NON-HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
10. FACILITY NAME (If not institution, give street address) Village Las Palmas Circle #21		11a. CITY, TOWN, OR LOCATION OF DEATH Saint Augustine	
12. MARITAL STATUS (Specify) <input type="checkbox"/> Married <input type="checkbox"/> Married, but Separated <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married		13. SURVIVING SPOUSE'S NAME (If wife, give maiden name)	
14a. RESIDENCE - STATE Florida		14b. COUNTY Saint Johns	
14c. CITY, TOWN, OR LOCATION Saint Augustine		14d. STREET ADDRESS Village Las Palmas Circle #21	
14e. APT. NO.		14f. ZIP CODE 32080	
14g. INSI CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. Do not use "Retired") Peace Activist		15b. KIND OF BUSINESS/INDUSTRY Political Social Arena	
16. DECEDENT'S RACE (Specify the race/faces to indicate what decedent considered himself/herself to be. More than one race may be specified.) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Specify tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Isl. (Specify) <input type="checkbox"/> Other (Specify)			
17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin) <input type="checkbox"/> Yes (If Yes, specify) <input checked="" type="checkbox"/> No <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central/South American <input type="checkbox"/> Other Hispanic (Specify) <input type="checkbox"/> Haitian			
18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death) <input type="checkbox"/> 8th or less <input type="checkbox"/> High school but no diploma <input type="checkbox"/> High school diploma or GED <input type="checkbox"/> College but no degree <input type="checkbox"/> College degree (Specify): _____ <input type="checkbox"/> Associate <input type="checkbox"/> Bachelor's <input checked="" type="checkbox"/> Master's <input type="checkbox"/> Doctorate			19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
20. FATHER'S NAME (First, Middle, Last, Suffix) Joseph Dallet		21. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Stern	
22a. INFORMANT'S NAME Joe McIntire		22b. RELATIONSHIP TO DECEDENT Son	
23a. CITY OR TOWN Saint Augustine		23b. STREET ADDRESS 7265 A1A South, D-1	
23c. STATE Florida		23d. ZIP CODE 32010	
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Volusia Crematory		25a. LOCATION - STATE Florida	
25b. LOCATION - CITY OR TOWN Daytona Beach		26. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)	
26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27a. LICENSE NUMBER (of Licensee) FO42783	
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Michael J. [Signature]</i>		27c. TIME OF DEATH (24 hr)	
28. NAME OF FUNERAL FACILITY Volusia County Cremation Services		29a. FACILITY'S MAILING STATE Florida	
29b. CITY OR TOWN Daytona Beach		29c. STREET ADDRESS 1428 Bellevue Avenue	
29d. ZIP CODE 32114			
30. CERTIFIER: <input checked="" type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated.			
31a. (Signature and Title of Certifier) <i>[Signature]</i>		31b. DATE SIGNED (mm/dd/yyyy) 06/12/2008	
31c. TIME OF DEATH (24 hr) 0022		31d. MEDICAL EXAMINER'S CASE NUMBER	
34a. LICENSE NUMBER (of Certifier) ME0056729		34b. CERTIFIER'S NAME Roy H. Hinman II, M.D.	
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)		36a. CERTIFIER'S STATE Florida	
36b. CITY OR TOWN Palm Coast		36c. STREET ADDRESS 264 Palm Coast Parkway, NE	
36d. ZIP CODE 32137		37. SUBREGISTRAR - Signature and Date <i>Carol Medeiros CDR</i> JUN 20 2008	
39. PROBABLE MANNER OF DEATH (The following are under the jurisdiction of the medical examiner: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined		40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
41. CAUSE OF DEATH - PART I (See instructions on back) Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. IMMEDIATE CAUSE (Final disease or condition resulting in death) NATURAL CAUSE		Approximate Interval: One 1 to Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.		42a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		43a. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY	
43b. DATE OF SURGERY (Mo., Day, Yr.)		44. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
46. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If Yes, specify timeframe: _____ at time of death _____ within 1 to 42 days of death _____ within 43 days to 1 year of death			
46. DATE OF INJURY (Month, Day, Year)		47. TIME OF INJURY (24 hr.)	
48. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		49a. LOCATION OF INJURY - STATE	
49b. CITY OR TOWN		49c. STREET ADDRESS	
49d. APT. NO.		49e. ZIP CODE	
50. DESCRIBE HOW INJURY OCCURRED		51. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)	
IF TRANSPORTATION INJURY, 52a. Status of Decedent <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)			
52b. Type of Vehicle <input type="checkbox"/> Car/Minivan <input type="checkbox"/> S.U.V. <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pickup Truck/Cargo Van <input type="checkbox"/> Bus <input type="checkbox"/> Heavy Transport <input type="checkbox"/> Other (Specify)			

VOID IF ALTERED OR ERASED

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WARNING:

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.



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CERTIFICATION OF VITAL RECORD



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JUN 20 2008

Carol Medeiros CDR