

00H-1961 (10/2003) NEW YORK STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH STATE FILE NUMBER

RECORDED DISTRICT: 2201 REGISTER NUMBER: 10661

RESIDENCE: NCHS

1. NAME: FIRST: Sarah MIDDLE: Hastinas LAST: Hastinas

2. SEX: MALE: 1 FEMALE: 2

3A. DATE OF DEATH: MONTH: 12 DAY: 18 YEAR: 1913

3B. HOUR: 1

4A. PLACE OF DEATH: (Check one) HOSPITAL DOA: 1 ER: 2 HOSPITAL OUTPATIENT: 3 HOSPITAL INPATIENT: 4 NURSING HOME: 5 PRIVATE RESIDENCE: 6 HOSPICE FACILITY: 7 OTHER (Specify): 8

4B. IF FACILITY: DATE ADMITTED: MONTH: DAY: YEAR:

4C. NAME OF FACILITY: (If not facility, give address) 908 Salina Street

4D. LOCALITY: (Check one and specify) CITY: 1 VILLAGE: 2 TOWN: 3 Watertown

4E. COUNTY OF DEATH: Jefferson

4F. MEDICAL RECORD NO. 4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO: 1 YES: 2

5. DATE OF BIRTH: MONTH: DAY: YEAR: 6A. AGE IN YEARS: 81 yrs.

6B. IF UNDER 1 YEAR ENTER: months: days: 6C. IF UNDER 1 DAY ENTER: hours: minutes: 7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) St. Lawrence Co, NY

7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO: 1 YES: 2

9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. A: 1 No, not Spanish/Hispanic/Latino B: 2 Yes, Mexican, Mexican American, Chicano C: 3 Yes, Puerto Rican D: 4 Yes, Cuban E: 5 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: 1 White/Caucasian B: 2 Black or African American C: 3 Asian Indian D: 4 Chinese E: 5 Filipino F: 6 Japanese G: 7 Korean H: 8 Vietnamese I: 9 Native Hawaiian J: 10 Guamanian or Chamorro K: 11 Samoan L: 12 American Indian or Alaska Native (specify): M: 13 Other Asian (specify): N: 14 Other Pacific Islander (specify): O: 15 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: 1 < 8th grade 2: 2 9th-12th grade; no diploma 3: 3 High school graduate or GED 4: 4 Some college credit, but no degree 5: 5 Associate's degree 6: 6 Bachelor's degree 7: 7 Master's degree 8: 8 Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER: 13. MARITAL STATUS: NEVER MARRIED: 1 MARRIED: 2 WIDOWED: 3 DIVORCED: 4 SEPARATED: 5

14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name.

15A. USUAL OCCUPATION: (Do not enter retired) NONE

15B. KIND OF BUSINESS OR INDUSTRY:

15C. NAME AND LOCALITY OF COMPANY OR FIRM:

16A. RESIDENCE: (State or Country if not USA) NY

16B. County or Region/Province if not USA: Jefferson

16C. LOCALITY: (Check one and specify) CITY: 1 VILLAGE: 2 TOWN: 3 Watertown

16D. STREET AND NUMBER OF RESIDENCE: 908 Salina Street

16E. ZIP CODE:

17. NAME OF FATHER: FIRST: MI: LAST: Ira Bellinger

18. MAIDEN NAME OF MOTHER: FIRST: MI: LAST: Unknown

19A. NAME OF INFORMANT: 19B. MAILING ADDRESS: (include zip code)

20A. 1: 1 BURIAL 2: 2 CREMATION 3: 3 REMOVAL MONTH: DAY: YEAR: 4: 4 HOLD DAY: 5: 5 DONATION YEAR: 6: 6 ENTOMBMENT

20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Hewvelton, NY

20C. LOCATION: (City or town and state) Hewvelton, NY

21A. NAME AND ADDRESS OF FUNERAL HOME: 21B. REGISTRATION NUMBER:

22A. NAME OF FUNERAL DIRECTOR: 22B. SIGNATURE OF FUNERAL DIRECTOR: 22C. REGISTRATION NUMBER:

23A. SIGNATURE OF REGISTRAR: 23B. DATE FILED: MONTH: DAY: YEAR: 24A. BURIAL OR REMOVAL PERMIT ISSUED BY: 24B. DATE ISSUED: MONTH: DAY: YEAR:

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

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: J.B. Smith License No.: Signature: Month: Day: Year:

25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: Month: Day: Year:

25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Signature: Month: Day: Year:

26A. Attending physician attended deceased: FROM: Month: Day: Year: TO: Month: Day: Year: 26B. Deceased last seen alive by attending physician: Month: Day: Year: 26C. Pronounced Dead: ON: Month: Day: Year: AT: Month: Day: Year:

27. MANNER OF DEATH: NATURAL CAUSE: 1 ACCIDENT: 2 HOMICIDE: 3 SUICIDE: 4 UNDETERMINED CIRCUMSTANCES: 5 PENDING INVESTIGATION: 6 28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0: 0 NO 1: 1 YES 29A. AUTOPSY? NO: 0 YES: 1 REFUSED: 2 29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0: 0 NO 1: 1 YES

CONFIDENTIAL SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH CONFIDENTIAL

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).)

PART I. IMMEDIATE CAUSE: (A) Cerebral Hemorrhage

DUE TO OR AS A CONSEQUENCE OF: (B)

DUE TO OR AS A CONSEQUENCE OF: (C)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):

31A. IF INJURY, DATE: MONTH: DAY: YEAR: HOUR: 31B. INJURY LOCALITY: (City or town and county and state) 31C. DESCRIBE HOW INJURY OCCURRED: 31D. PLACE OF INJURY: 31E. INJURY: NO: 0 YES: 1

31F. IF TRANSPORTATION INJURY, SPECIFY: 1: 1 Driver/Operator 2: 2 Passenger 3: 3 Pedestrian 32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO: 0 YES: 1 33A. IF FEMALE: 0: 0 Not pregnant within last year 1: 1 Pregnant at time of death 2: 2 Not pregnant, but pregnant within 42 days of death 33B. DATE OF DELIVERY: MONTH: DAY: YEAR: