NEW YORK STATE — LOCAL REGISTRAR COPY

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED DISTRICT: 5657

REGISTER NUMBER: 2F

1. NAME: FIRST MARION (Marion) MIDDLE B. LAST LACIVITA (Lacivita)

2. SEX: MALE ☐ 1 FEMALE ☒ 2

3A. DATE OF DEATH: MONTH May DAY 14 YEAR 95

3B. HOUR: 3:06A m

RESIDENCE

4A. PLACE OF DEATH: (Check only one) HOSPITAL DOA ☐ 1 ER ☐ 2 HOSPITAL OUTPATIENT ☐ 3 HOSPITAL INPATIENT ☐ 4 NURSING HOME ☒ PRIVATE RESIDENCE ☐ OTHER (Specify)

4B. IF FACILITY, DATE ADMITTED: MONTH May DAY 30 YEAR 91

NCHS

4C. NAME OF FACILITY: (If not facility give address) Hallmark Nursing Centre

4D. LOCALITY: (Check one and specify) CITY OF ☐ VILLAGE OF ☐ TOWN OF ☒ Queensbury

4E. COUNTY OF DEATH: Warren

4C

4F. MEDICAL RECORD NO. 080 07 8929

4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☒ YES ☐

4G

DECEDENT

5. DATE OF BIRTH: MONTH Dec DAY 15 YEAR 1914

6. AGE: 80 yrs. IF UNDER 1 YEAR months days IF UNDER 1 DAY hours minutes

7A. CITY AND STATE OF BIRTH: (Country if not U.S.A.) Troy, NY

7A

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

8. SERVED IN U.S. ARMED FORCES? NO ☒ 0 YES ☐ 1 (Specify years)

9. RACE: (Black, White, etc.) white

10. HISPANIC ORIGIN? (If yes, specify) NO ☒ YES ☐

11. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)

7B

12. SOCIAL SECURITY NUMBER: 080-07-8929

13. MARITAL STATUS: NEVER MARRIED ☐ 1 MARRIED OR SEPARATED ☐ 2 WIDOWED ☒ 3 DIVORCED ☐ 4

14. SURVIVING SPOUSE: (If wife, provide maiden name) deceased

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15A. USUAL OCCUPATION: (Do not enter retired) Real Estate Agent

15B. KIND OF BUSINESS OR INDUSTRY: Real Estate Self Employed

15C. NAME AND LOCALITY OF COMPANY OR FIRM: LaCivita Reality Florida

16A. RESIDENCE, STATE: New York

16B. COUNTY: Warren

16C. LOCALITY: (Check one and specify) CITY OF ☐ VILLAGE OF ☐ TOWN OF ☒ Queensbury

16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☐ YES ☒ NO IF NO, SPECIFY TOWN:

10

16D. STREET AND NUMBER OF RESIDENCE: 152 Sherman Ave.

16E. ZIP CODE: 12804 Queensbury

PARENTS

17. NAME OF FATHER: FIRST James MI LAST Boyle

SI

18. MAIDEN NAME OF MOTHER: FIRST Elizabeth MI LAST Ornsby

19A. NAME OF INFORMANT: Mary Butterfield

19B. MAILING ADDRESS: (Include zip code) 88 Webster Ave. Glens Falls, NY 12801

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DISPOSITION

20A. BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: (Specify) Burial MONTH May DAY 18 YEAR 95

20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: St. Mary's Cemetery

20C. LOCATION: (City or town and state) So. Glens Falls, NY

30

21A. NAME AND ADDRESS OF FUNERAL HOME: Singleton Healy Funeral Home, Inc. 407 Bay Rd Queensbury, NY 12804

21B. REGISTRATION NUMBER: 01807

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22A. NAME OF FUNERAL DIRECTOR: Bernard W. Healy

22B. SIGNATURE OF FUNERAL DIRECTOR: Bernard W. Healy

22C. REGISTRATION NUMBER: 02207

31B

23A. SIGNATURE OF REGISTRAR: Kathleen Doyle

23B. DATE FILED: MONTH 5 DAY 15 YEAR 95

24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Kathleen Doyle

24B. DATE ISSUED: MONTH 5 DAY 15 YEAR 95

ITEMS 25 - 33 COMPLETED BY CERTIFYING PHYSICIAN — OR — ITEMS 25 - 33 COMPLETED BY CORONER OR MEDICAL EXAMINER

QR

CERTIFIER

25A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED. SIGNATURE: [signature] MONTH 5 DAY 14 YEAR 95

25A. ON THE BASIS OF INVESTIGATION AND SUCH EXAMINATIONS, AS I FELT NECESSARY, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED. SIGNATURE AND TITLE: ▶ ☐ CORONER ☐ CORONER'S PHYSICIAN ☐ MEDICAL EXAMINER

QS

25B. THE PHYSICIAN ATTENDED THE DECEASED FROM MONTH 5 DAY 30 YEAR 91 TO MONTH 5 DAY 14 YEAR 95

25C. LAST SEEN ALIVE: MONTH 5 DAY 14 YEAR 95

25B. PRONOUNCED DEAD ON MONTH DAY YEAR

25C. HOUR: m

25D. DATE SIGNED: MONTH DAY YEAR

QCOD

25D. NAME OF ATTENDING PHYSICIAN: PATRICIA HALE

25E. SIGNATURE OF CORONER OR CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER:

CANCER

25D. ATTENDING PHYSICIAN LICENSE NUMBER 172396

25F. ME/COR. PHYS. LICENSE NUMBER

26. NAME AND ADDRESS OF CERTIFIER WHO SIGNED 25A: PATRICIA HALE 7245 Upper Broadway Ft Edward NY 12828

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? NO ☒ 0 YES ☐ 1

29A. AUTOPSY? NO ☒ 0 YES ☐ 1

29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? NO ☐ 0 YES ☐ 1

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

CAUSE OF DEATH

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

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. IMMEDIATE CAUSE: (A) Cardiopulmonary arrest — Immediate

DUE TO OR AS A CONSEQUENCE OF: (B) CHF — ~6 months

DUE TO OR AS A CONSEQUENCE OF: (C) severe Atherosclerotic Cardiovascular dz — years

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

31A. IF INJURY, DATE: MONTH DAY YEAR HOUR: m

31B. LOCALITY: (City or town and county and state)

31C. DESCRIBE HOW INJURY OCCURRED:

Disappears With Heat

31D. PLACE:

31E. AT WORK? NO ☐ 0 YES ☐ 1

32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☒ 0 YES ☐ 1

33A. IF FEMALE, WAS DECEDENT PREGNANT IN LAST 6 MONTHS? NO ☒ 0 YES ☐ 1

33B. DATE OF DELIVERY: MONTH DAY YEAR

NAME OF DECEDENT: _____ *For use by physician or institution

DOH-1961 (1/91)

VS-60