COPY

box #55 amended to correct SS#. as per daughter-
3-23-11 RW

VS-4 REV. 1/04
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER (For State Use only. Do not write in this box)

180

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last): Jean Yerks
2. SEX: ☐ Male ☒ Female
3. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) (Spell Month): 12-4-2010
4. ACTUAL OR PRESUMED TIME OF DEATH: 9:55 ☒ AM ☐ PM

5. AGE LAST BIRTHDAY: 67
6. UNDER 1 YEAR: Mo. / Days — UNDER 1 DAY: Hours / Min.
7. DATE OF BIRTH (MM/DD/YYYY): 3-31-1943
8. BIRTHPLACE (City, State or Foreign Country): Stamford, Connecticut

9. RESIDENCE (State): New York
10. RESIDENCE (County): Westchester
11. RESIDENCE (City or Town): Port Chester
12. RESIDENCE (Street and No.): 315 King St
13. APT. NO.: 4-I

14. ZIP CODE: 10573
15. EVER IN US ARMED FORCES? ☐ Yes ☒ No
16. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married but separated ☐ Widowed ☒ Divorced ☐ Never Married ☐ Unknown
17. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage):

18. FATHER'S NAME (First, Middle, Last): George Condos
19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Patricia Smith

20. INFORMANT'S NAME: Colleen Hayes
21. INFORMANT'S RELATIONSHIP TO DECEDENT: Daughter
22. MAILING ADDRESS (Street and Number, City, State, Zip Code): 5 Owl Hill Dr. Monroe, CT 06468

23. IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ ER/outpatient ☐ Dead on Arrival
24. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice Facility ☒ Nursing Home ☐ Decedent's Home ☐ Other (specify)
25. FACILITY NAME (If not institution, give street & number): Masonic Care at Newtown

26. CITY OR TOWN OF DEATH: Newtown — ZIP CODE:
27. COUNTY OF DEATH: Fairfield
28. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (specify)

29. DISPOSITION (Name of cemetery, crematory, other place): CT. Crematory Corp.
30. LOCATION (city/town, state): Stamford CT.
31. DATE (MM/DD/YYYY): 12-7-10
32. WAS BODY EMBALMED? *If yes, Name of Embalmer ☐ Yes* ☒ No;

33. FUNERAL FACILITY - Name and Address (street, town, state, zip): Craft Memorial Home 40 Leicester St. Port Chester NY 10573
34. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER: Michelle Meyer
35. LICENSE NUMBER OF SIGNEE IN BOX 34: 002338

36. DATE PRONOUNCED DEAD (MM/DD/YYYY): 12/04/2010
37. TIME PRONOUNCED: 9:55 AM
38. NURSE PRONOUNCEMENT NAME AND DEGREE OR TITLE (Print): Hope Melbourne RN
39. SIGNATURE: Hope Melbourne RN
40. DATE SIGNED: 12/04/2010

41. WAS MEDICAL EXAMINER CONTACTED? ☒ Yes ☐ No
42. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No
43. WERE THE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

CAUSE OF DEATH

44. PART I. Enter the chain of events - diseases, injuries, or complications-that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		APPROXIMATE INTERVAL ONSET TO DEATH
IMMEDIATE CAUSE (Final disease or condition resulting in death) --------------->	(a) lung cancer	Year
Sequentially list conditions, if any, leading to the cause listed on line (a). Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**	Due to (or as a consequence of): (b)	
	Due to (or as a consequence of): (c)	
	Due to (or as a consequence of): (d)	

45. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
46. IF FEMALE: ☒ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year
47. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☒ Probably ☐ No ☐ Unknown

48. CERTIFIER (Check only one box) ☐ Certifying practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge death occurred due to the cause(s) and manner stated. ☐ Pronouncing & Certifying Practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated.

Certifier Name (Type or Print): Yvette Fernandez — Certifier Signature: [signature] — Title of Certifier: M.D. — Date Certified: 12/6/2010

49. MAILING - CERTIFIER (Street) (City or Town): Sandy Hook (State) (Zip)

THIS CERTIFICATE WAS RECEIVED FOR RECORD ON: 12-6-10 — BY — REGISTRAR: Debbie A Aurelia

50. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death. ☐ 8th grade or less ☐ 9th - 12th grade, no diploma ☒ High School Graduate/GED ☐ Some college credit, but no degree ☐ Associate degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate or Professional degree ☐ Unknown ☐ Not available

51. DECEDENT OF HISPANIC ORIGIN? ☒ No, Not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (specify)

52. DECEDENT'S RACE: ☒ White ☐ Black or African American ☐ Asian Indian ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (specify) ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (specify) ☐ Other (specify)

53. DECEDENT'S USUAL OCCUPATION: Owner
54. KIND OF BUSINESS/INDUSTRY: Service Bureau
55. SOCIAL SECURITY NUMBER: ~~049-32-5051~~ 049-32-5150

I Certify that this is a copy of the certificate received for record.
Attest: Debbie A Aurelia Registrar