

NEW YORK STATE  
DEPARTMENT OF HEALTH  
CERTIFICATE  
OF DEATH

STATE FILE NUMBER

1 3 1 9 6 0 0 7 6 0 6

5950  
RESIDENCE

RECORDED DISTRICT  
5946  
REGISTER NUMBER  
21

1. NAME: FIRST JOHN MIDDLE JOSEPH LAST HAYES		2. SEX: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	3A. DATE OF DEATH: MONTH 1 DAY 14 YEAR 96	3B. HOUR: 8 A. m
4A. PLACE OF DEATH: (Check only one) HOSPITAL DOA <input checked="" type="checkbox"/> ER <input type="checkbox"/> HOSPITAL OUTPATIENT <input type="checkbox"/> HOSPITAL INPATIENT <input type="checkbox"/> NURSING HOME <input type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> OTHER (Specify)		4B. IF FACILITY DATE ADMITTED: MONTH DAY YEAR		
4C. NAME OF FACILITY: (If not facility give address) Northern Westchester Hospital		4D. LOCALITY: (Check one and specify) CITY OF Westchester VILLAGE OF Kisco TOWN OF		4E. COUNTY OF DEATH: Westchester
4F. MEDICAL RECORD NO. 130482		4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		
5. DATE OF BIRTH: MONTH DAY YEAR Jan 2 1922		6. AGE: 74 yrs.	7A. CITY AND STATE OF BIRTH: (Country if not U.S.A.) New Manchester, Hampshire	
8. SERVED IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> (Specify years)		9. RACE: (Black, White, etc.) White	10. HISPANIC ORIGIN? (If yes, specify) NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>	
11. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		14. SURVIVING SPOUSE: (If wife, provide maiden name) Jeanne Lewis		
12. SOCIAL SECURITY NUMBER: 037-12-1882		13. MARITAL STATUS: NEVER MARRIED <input type="checkbox"/> MARRIED OR SEPARATED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
15A. USUAL OCCUPATION: (Do not enter retired) Chemical Sales		15B. KIND OF BUSINESS OR INDUSTRY: Chemical Sales and Development		
15C. NAME AND LOCALITY OF COMPANY OR FIRM: Ciba-Geigy Corp.		Ardsley, N.Y.		
16A. RESIDENCE, STATE: New York		16B. COUNTY: Westchester		16C. LOCALITY: (Check one and specify) CITY OF Bedford VILLAGE OF TOWN OF
16D. STREET AND NUMBER OF RESIDENCE: 29 Old Deer Park Road, Katonah, N.Y.		16E. ZIP CODE: 10536		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SPECIFY TOWN: Bedford
17. NAME OF FATHER: FIRST MI LAST Jeremiah Joseph Hayes		18. MAIDEN NAME OF MOTHER: FIRST MI LAST Margaret Sheehan		
19A. NAME OF INFORMANT: Jeanne T. Hayes		19B. MAILING ADDRESS: (Include zip code) 29 Old Deer Park Road, Katonah, N.Y. 10536		
20A. BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: (Specify) Burial		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Fair Ridge Cemetery		20C. LOCATION: (City or town and state) Chappaqua, N.Y.
21A. NAME AND ADDRESS OF FUNERAL HOME: Clark Associates Funeral Home, 4 Woods Bridge Rd., Katonah, N.Y.		21B. REGISTRATION NUMBER: 00366		
22A. NAME OF FUNERAL DIRECTOR: Bruce E. Reisdorf		22B. SIGNATURE OF FUNERAL DIRECTOR: <i>Bruce E. Reisdorf</i>		22C. REGISTRATION NUMBER: 04261
23A. SIGNATURE OF REGISTRAR: <i>Jeanne T. Hayes</i>		23B. DATE FILED: MONTH DAY YEAR 1 14 96		24A. BURIAL OR REMOVAL PERMIT ISSUED BY: <i>Jeanne T. Hayes</i>
23C. DATE ISSUED: MONTH DAY YEAR 1 14 96		24B. DATE ISSUED: MONTH DAY YEAR 1 14 96		
ITEMS 25 - 33 COMPLETED BY CERTIFYING PHYSICIAN OR ITEMS 25 - 33 COMPLETED BY CORONER OR MEDICAL EXAMINER				
25A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED. SIGNATURE: <i>Howard Reimer</i> MONTH DAY YEAR 1 14 96		25B. 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: <i>JB</i>		
25B. THE PHYSICIAN ATTENDED THE DECEASED FROM MONTH DAY YEAR 1 14 96 TO MONTH DAY YEAR 1 14 96		25C. LAST SEEN ALIVE BY ATTENDANT: MONTH DAY YEAR 1 14 96		25D. PRONOUNCED DEAD BY ATTENDANT: MONTH DAY YEAR
25D. NAME OF ATTENDING PHYSICIAN: Howard Reimer		25E. SIGNATURE OF CORONER OR CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER: <i>JB</i>		
25E. ATTENDING PHYSICIAN LICENSE NUMBER: 10175		25F. MEICOR PHYS. LICENSE NUMBER: 10175		
26. NAME AND ADDRESS OF CERTIFIER WHO SIGNED 25A: Howard Reimer 711 Duane Rd Katonah N.Y. 10536		28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>		
27. MANNER OF DEATH: NATURAL CAUSE <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED CIRCUMSTANCES <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/>		29A. AUTOPSY? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> REFUSED <input type="checkbox"/>		29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? NO <input type="checkbox"/> YES <input type="checkbox"/>

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31B

QR

QS

QCOD

CANCER

DECEDENT  
FATHER  
DISPOSITION  
CERTIFIER