U.S. STANDARD CERTIFICATE OF LIVE BIRTH

LOCAL FILE NO.

BIRTH NUMBER:

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)
2. TIME OF BIRTH (24 hr)
3. SEX
4. DATE OF BIRTH (Mo/Day/Yr)
5. FACILITY NAME (If not institution, give street and number)
6. CITY, TOWN, OR LOCATION OF BIRTH
7. COUNTY OF BIRTH

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
8b. DATE OF BIRTH (Mo/Day/Yr)
8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)
8d. BIRTHPLACE (State, Territory, or Foreign Country)
9a. RESIDENCE OF MOTHER-STATE
9b. COUNTY
9c. CITY, TOWN, OR LOCATION
9d. STREET AND NUMBER
9e. APT. NO.
9f. ZIP CODE
9g. INSIDE CITY LIMITS? □ Yes □ No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11. CERTIFIER'S NAME: ______________________
TITLE: □ MD □ DO □ HOSPITAL ADMIN. □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)______________________
12. DATE CERTIFIED ____/____/______ MM DD YYYY
13. DATE FILED BY REGISTRAR ____/____/______ MM DD YYYY

INFORMATION FOR ADMINISTRATIVE USE

MOTHER

14. MOTHER'S MAILING ADDRESS: 9 Same as residence, or: State: City, Town, or Location:
Street & Number: Apartment No.: Zip Code:
15. MOTHER MARRIED? (At birth, conception, or any time between) □ Yes □ No
IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? □ Yes □ No
16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? □ Yes □ No
17. FACILITY ID. (NPI)
18. MOTHER'S SOCIAL SECURITY NUMBER:
19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
- □ 8th grade or less
- □ 9th - 12th grade, no diploma
- □ High school graduate or GED completed
- □ Some college credit but no degree
- □ Associate degree (e.g., AA, AS)
- □ Bachelor's degree (e.g., BA, AB, BS)
- □ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- □ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)
- □ No, not Spanish/Hispanic/Latina
- □ Yes, Mexican, Mexican American, Chicana
- □ Yes, Puerto Rican
- □ Yes, Cuban
- □ Yes, other Spanish/Hispanic/Latina

(Specify)______________________

22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
- □ White
- □ Black or African American
- □ American Indian or Alaska Native (Name of the enrolled or principal tribe)______________
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian (Specify)______________
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Pacific Islander (Specify)______________
- □ Other (Specify)______________

FATHER

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
- □ 8th grade or less
- □ 9th - 12th grade, no diploma
- □ High school graduate or GED completed
- □ Some college credit but no degree
- □ Associate degree (e.g., AA, AS)
- □ Bachelor's degree (e.g., BA, AB, BS)
- □ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- □ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)
- □ No, not Spanish/Hispanic/Latino
- □ Yes, Mexican, Mexican American, Chicano
- □ Yes, Puerto Rican
- □ Yes, Cuban
- □ Yes, other Spanish/Hispanic/Latino

(Specify)______________________

25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
- □ White
- □ Black or African American
- □ American Indian or Alaska Native (Name of the enrolled or principal tribe)______________
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian (Specify)______________
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Pacific Islander (Specify)______________
- □ Other (Specify)______________

Mother's Name

Mother's Medical Record No.

26. PLACE WHERE BIRTH OCCURRED (Check one)
- □ Hospital
- □ Freestanding birthing center
- □ Home Birth: Planned to deliver at home? 9 Yes 9 No
- □ Clinic/Doctor's office
- □ Other (Specify)______________

27. ATTENDANT'S NAME, TITLE, AND NPI
NAME: ______________ NPI:________
TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)______________

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? □ Yes □ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:
____

REV. 11/2003

MOTHER

29a. DATE OF FIRST PRENATAL CARE VISIT
___/___/______ ☐ No Prenatal Care
MM DD YYYY

29b. DATE OF LAST PRENATAL CARE VISIT
___/___/______
MM DD YYYY

30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
__________ (If none, enter A0".)

31. MOTHER'S HEIGHT
______ (feet/inches)

32. MOTHER'S PREPREGNANCY WEIGHT
______ (pounds)

33. MOTHER'S WEIGHT AT DELIVERY
______ (pounds)

34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)

35a. Now Living
Number ____
☐ None

35b. Now Dead
Number ____
☐ None

35c. DATE OF LAST LIVE BIRTH
___/______
MM YYYY

36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

36a. Other Outcomes
Number ____
☐ None

36b. DATE OF LAST OTHER PREGNANCY OUTCOME
___/______
MM YYYY

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER A0".

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	______	OR	______
First Three Months of Pregnancy	______	OR	______
Second Three Months of Pregnancy	______	OR	______
Third Trimester of Pregnancy	______	OR	______

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
☐ Private Insurance
☐ Medicaid
☐ Self-pay
☐ Other (Specify) ______

39. DATE LAST NORMAL MENSES BEGAN
___/___/______
MM DD YYYY

40. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH INFORMATION

41. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

☐ Previous preterm birth

☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment-If yes, check all that apply:
- ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))

☐ Mother had a previous cesarean delivery
If yes, how many ______

☐ None of the above

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ None of the above

43. OBSTETRIC PROCEDURES (Check all that apply)
- ☐ Cervical cerclage
- ☐ Tocolysis

External cephalic version:
- ☐ Successful
- ☐ Failed

☐ None of the above

44. ONSET OF LABOR (Check all that apply)
- ☐ Premature Rupture of the Membranes (prolonged, 312 hrs.)
- ☐ Precipitous Labor (<3 hrs.)
- ☐ Prolonged Labor (3 20 hrs.)
- ☐ None of the above

45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature >38°C (100.4°F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

46. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No

C. Fetal presentation at birth
- ☐ Cephalic
- ☐ Breech
- ☐ Other

D. Final route and method of delivery (Check one)
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
- ☐ Cesarean
  If cesarean, was a trial of labor attempted?
  - ☐ Yes
  - ☐ No

47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☐ None of the above

NEWBORN INFORMATION

NEWBORN

48. NEWBORN MEDICAL RECORD NUMBER

49. BIRTHWEIGHT (grams preferred, specify unit)
____
9 grams 9 lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION:
__________ (completed weeks)

51. APGAR SCORE:
Score at 5 minutes: ______
If 5 minute score is less than 6,
Score at 10 minutes: ______

52. PLURALITY - Single, Twin, Triplet, etc.
(Specify) ______

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) ______

54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
- ☐ Assisted ventilation required immediately following delivery
- ☐ Assisted ventilation required for more than six hours
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)

9 None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Cleft Lip with or without Cleft Palate
- ☐ Cleft Palate alone
- ☐ Down Syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the anomalies listed above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: ______

57. IS INFANT LIVING AT TIME OF REPORT?
☐ Yes ☐ No ☐ Infant transferred, status unknown

58. IS THE INFANT BEING BREASTFED AT DISCHARGE?
☐ Yes ☐ No

Mother's Name

Mother's Medical Record No. ______

STATE OF VERMONT

CERTIFICATION OF VITAL RECORD

FILED

JUN 16 2016

Vermont Superior Court

Windham Unit

VH-PHS-BIR-2005

C70514

DEPARTMENT OF HEALTH

VERMONT CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

144 12005127

STATE FILE NUMBER

CHILD

1. CHILD'S NAME - (FIRST, MIDDLE, LAST, SUFFIX)	2a. DATE OF BIRTH - (MONTH, DAY, YEAR)	2b. TIME OF BIRTH

3. SEX	4a. PLURALITY - SINGLE, TWIN ETC. (SPECIFY)	4b. IF NOT SINGLE BIRTH - BORN FIRST, SECOND, ETC. (SPECIFY)	5a. PLACE OF BIRTH
Female	Single		Hospital

5b. CITY OR TOWN OF BIRTH	5c. FACILITY NAME - (IF NOT IN FACILITY, GIVE STREET ADDRESS AND NUMBER)
Brattleboro	Brattleboro Memorial Hospital

PARENTS

6. MOTHER'S NAME - (FIRST, MIDDLE, LAST, SUFFIX)	7. DATE OF BIRTH - (MONTH, DAY, YEAR)

8. MOTHER'S BIRTH NAME - (LAST NAME ONLY)	9. MOTHER'S BIRTHPLACE - (STATE OR FOREIGN COUNTRY)

10a. RESIDENCE OF MOTHER - STREET AND NUMBER	10b. CITY OR TOWN	10c. STATE

11. FATHER'S NAME - (FIRST, MIDDLE, LAST, SUFFIX)	12. DATE OF BIRTH - (MONTH, DAY, YEAR)

13. FATHER'S BIRTHPLACE - (STATE OR FOREIGN COUNTRY)

CERTIFIER

14a. CERTIFIER'S NAME	14b. TITLE	14c. DATE CERTIFIED - (MONTH, DAY, YEAR)
Brittany Parent	Hospital Administrator	November 26, 2012

15a. ATTENDANT'S NAME - (IF OTHER THAN CERTIFIER)	15b. TITLE
Lois B. Trezise	CNM/CM

REGISTRAR

16a. REGISTRAR - SIGNATURE	16b. DATE RECEIVED BY LOCAL REGISTRAR (MONTH, DAY, YEAR)
Annette L. Cappy, Town Clerk	November 27, 2012

17a. TRUE COPY - CLERK SIGNATURE	17b. TOWN	17c. DATE - (MONTH, DAY, YEAR)
ATTEST: Annette L. Cappy	BRATTLEBORO	DEC 4 2012

Photocopy from original made by Court staff

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AND PLACED ON FILE IN THIS OFFICE.

DATE ISSUED: DEC 2 4 2012

ATTEST: Harry Chen MD

VERMONT

This copy not valid unless prepared on engraved border displaying state seal of Vermont.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

STATE OF VERMONT
CERTIFICATION OF VITAL RECORD

DH-PHS-BIR-2012 078453

DEPARTMENT OF HEALTH
VERMONT CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

144 16002581
STATE FILE NUMBER

TYPE OR PRINT IN PERMANENT BLACK INK

CHILD

1. CHILD'S NAME - (FIRST, MIDDLE, LAST, SUFFIX)	2a. DATE OF BIRTH - (MONTH, DAY, YEAR)	2b. TIME OF BIRTH
		10:10 AM

3. SEX	4a. PLURALITY - SINGLE, TWIN, ETC. (SPECIFY)	4b. IF NOT SINGLE BIRTH - BORN FIRST, SECOND, ETC. (SPECIFY)	5a. PLACE OF BIRTH
Male	Single		Hospital

5b. CITY OR TOWN OF BIRTH	5c. FACILITY NAME - (IF NOT IN FACILITY, GIVE STREET ADDRESS AND NUMBER)
Middlebury	Porter Medical Center

PARENTS

6. NAME - (FIRST, MIDDLE, LAST, SUFFIX)	7. DATE OF BIRTH - (MONTH, DAY, YEAR)

8. LAST NAME AT BIRTH	9. BIRTHPLACE - (STATE OR FOREIGN COUNTRY)

10a. RESIDENCE - STREET AND NUMBER	10b. CITY OR TOWN	10c. STATE

11. NAME - (FIRST, MIDDLE, LAST, SUFFIX)	12. DATE OF BIRTH - (MONTH, DAY, YEAR)

13. BIRTHPLACE - (STATE OR FOREIGN COUNTRY)

CERTIFIER

14a. CERTIFIER'S NAME	14b. TITLE	14c. DATE CERTIFIED - (MONTH, DAY, YEAR)
Denise Roycewicz	Hospital Administrator	June 28, 2016

15a. ATTENDANT'S NAME - (IF OTHER THAN CERTIFIER)	15b. TITLE
Heather Brown Kidde	CNM/CM

REGISTRAR

16a. REGISTRAR - SIGNATURE	16b. DATE RECEIVED BY LOCAL REGISTRAR - (MONTH, DAY, YEAR)
Veronica Parrish	JUN 28 2016

TO BE SIGNED BY THE REGISTRAR ON COPY ONLY

17a. TRUE COPY - CLERK SIGNATURE	17b. TOWN	17c. DATE - (MONTH, DAY, YEAR)
ATTEST Veronica Parrish	MIDDLEBURY	JUN 29 2016

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE INFORMATION ON THE ORIGINAL CERTIFICATE ON FILE IN THE VERMONT DEPARTMENT OF HEALTH OR CUSTODIAL AGENCY

DATE ISSUED: JAN 23 2017

ATTEST: Commissioner
Vermont Department of Health

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ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

STATE OF VERMONT

DH-PHS-FB-2012

VERMONT DEPARTMENT OF HEALTH
CERTIFICATE OF LIVE BIRTH
FOR A FOREIGN BORN CHILD

FB-2016-150011
STATE FILE NUMBER

CHILD

1. CHILD'S NAME - (FIRST, MIDDLE, LAST, SUFFIX)	2. DATE OF BIRTH - (MONTH, DAY, YEAR)	3. SEX

4a. COUNTRY OF BIRTH	4b. STATE OR PROVINCE	4c. CITY, TOWN OR VILLAGE
China		

PARENTS

5. NAME - (FIRST, MIDDLE, LAST, SUFFIX)	6. DATE OF BIRTH - (MONTH, DAY, YEAR)
	[illegible]rch 13, 1970

7. LAST NAME AT BIRTH	8. BIRTHPLACE - (STATE OR FOREIGN COUNTRY)

9a. RESIDENCE - STREET AND NUMBER	9b. CITY OR TOWN	9c. STATE

10. NAME - (FIRST, MIDDLE, LAST, SUFFIX)	11. DATE OF BIRTH - (MONTH, DAY, YEAR)

12. BIRTHPLACE - (STATE OR FOREIGN COUNTRY)

13. SOURCE OF INFORMATION ABOVE
Decree issued October 13, 2016 by Orleans District Probate Court, Judge John P. Monette presiding.

THIS CERTIFICATE IS NOT EVIDENCE OF UNITED STATES CITIZENSHIP

CERTIFIER

14. THIS CERTIFICATE ISSUED PURSUANT TO TITLE 18, CHAPTER 103, V.S.A.
CYNTHIA M. HOOLEY — Cynthia M. Hooley — State Registrar

15. DATE CERTIFIED - (MONTH, DAY, YEAR)
November 09, 2016

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE INFORMATION ON THE ORIGINAL CERTIFICATE ON FILE IN THE VERMONT DEPARTMENT OF HEALTH OR CUSTODIAL AGENCY.

DATE ISSUED: JAN 23 2017

ATTEST: Commissioner
Vermont Department of Health

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VDH-PHS-BTP-2011

VERMONT DEPARTMENT OF HEALTH
BURIAL-TRANSIT PERMIT
Permit for Removal, Disinterment and Reinterment

Permit No. ________

1. Decedent's Name	2. Sex	3. Date of Death

4. City/Town of Death	5. Date of Birth	6. Place of Birth

7. Name and Address of Funeral Director

PERMISSION REQUESTED FOR: (Check only one box and complete the appropriate section)

- ☐ Temporary Storage or Donation (Section A)
- ☑ Cremation (Section C)
- ☐ Burial or Entombment (Section D)
- ☐ Removal From Temporary Storage/Place of Donation or Disinterment (Section B)
- ☐ Removal From State (Section E)

SECTION A: IF TEMPORARY STORAGE OR DONATION IN VERMONT

Name of Cemetery/Place or Donation Facility	City/Town	Date

PERMISSION GIVEN TO DISPOSE OF SAID BODY AS STATED ABOVE (Title 18, V.S.A. 5201)

Signature of Clerk/Deputy or Funeral Director	City/Town	Date

Signature of Sexton/Cemetery Official or Representative of Organization Receiving Donation	Date

SECTION B: IF REMOVAL FROM TEMPORARY STORAGE/PLACE OF DONATION OR DISINTERMENT

Name of Cemetery/Place or Facility from which body is being removed	City/Town	Date

PERMISSION GIVEN TO DISPOSE OF SAID BODY AS STATED ABOVE (Title 18, V.S.A. 5201)

Signature of Clerk/Deputy or Funeral Director	City/Town	Date

Signature of Sexton/Cemetery Official	Date

SECTION C: IF CREMATION IN VERMONT

Name of Crematorium	City/Town	Date
Mount Anthony Cremation Services, Inc.	Bennington	June 20, 2016

PERMISSION GIVEN TO DISPOSE OF SAID BODY AS STATED ABOVE (Title 18, V.S.A. 5201)

Signature of Clerk/Deputy or Funeral Director	City/Town	Date
[signature]	BENNINGTON	June 20, 2016

Signature of Crematorium Official	Container Number	Date
[signature]	110263	June 20, 2016

SECTION D: IF BURIAL OR ENTOMBMENT IN VERMONT

Name of Cemetery	City/Town	Date

PERMISSION GIVEN TO DISPOSE OF SAID BODY AS STATED ABOVE (Title 18, V.S.A. 5201)

Signature of Clerk/Deputy or Funeral Director	City/Town	Date

Body was: ☐ Buried ☐ Entombed — Date

Section	Lot Number	Grave Number	Signature of Sexton/Cemetery Official

SECTION E: IF REMOVAL FROM STATE

Name of Cemetery or Place to where body is being taken	City/Town, State or Country	Date

PERMISSION GIVEN TO DISPOSE OF SAID BODY AS STATED ABOVE (Title 18, V.S.A. 5201)

Signature of Clerk/Deputy or Funeral Director	City/Town	Date

This permit is to be filed with the City/Town Clerk by the 10th day of the month following disposition. (Title 18 V.S.A. 5215)

BTP-FET-89

VERMONT DEPARTMENT OF HEALTH
BURIAL - TRANSIT - DISPOSITION PERMIT FOR FETAL REMAINS

FETUS

FETUS NAME FIRST (If given) MIDDLE (If given) LAST 1.	DATE OF DELIVERY (Month, day, year) 2a.	HOUR 2b.

CITY, TOWN OF DELIVERY 2c.	HOSPITAL NAME (If not in hospital, give street and number) 2d.

SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN 3.	THIS DELIVERY: ☐ SINGLE ☐ TWIN ☐ TRIPLET ☐ .... BORN ☐ FIRST ☐ SECOND ☐ THIRD ☐ .... 4.	BIRTH WEIGHT 5.	WHEN DID FETUS DIE? ☐ BEFORE LABOR ☐ DURING LABOR OR DELIVERY ☐ UNKNOWN 6.

PARENTS

7a. MOTHER'S NAME (First, Middle, Last)	7b. MAIDEN SURNAME	8. DATE OF BIRTH (Month, Day, Year)

9a. RESIDENCE-STATE	9b. CITY OR TOWN	10. BIRTHPLACE (State or Foreign Country)

11. MOTHER'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12. FATHER'S NAME (First, Middle, Last)	13. DATE OF BIRTH (Month, Day, Year)	14. BIRTHPLACE (State or Foreign Country)

AUTHORITY FOR DISPOSITION:

This permit, when completed and bearing the name of a certifying physician, constitutes authority for final disposition of the fetal remains identified above. (Title 18, 5224 (a), V. S. A.)

CEMETERY SEXTON OR COMMERCIAL CREMATORY:

Complete the bottom line, and deliver to the Town or City Clerk on a monthly basis with other burial-transit permits. (Title 18, 5224 (b), V. S. A.)

CERTIFIER

Name of Certifying Physician 15a.	Date Completed 15b.
CERTIFIER-MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip) 15d.	MEDICAL EXAMINER (WHEN UNIDENTIFIED FETUS IS FOUND) 16.

DISPOSITION OF REMAINS

☐ BURIAL ☐ CREMATION ☐ HOSPITAL DISPOSITION ☐ OTHER 17a.	NAME OF CEMETERY, CREMATORY OR HOSPITAL MAKING DISPOSAL 17b.	LOCATION (CITY OR TOWN) 17c.

NAME OF FUNERAL DIRECTOR, IF ANY 17d.	ADDRESS 17e.

DATE OF BURIAL OR DISPOSITION	SECTION & LOT NO. (If applicable)	SIGNATURE OF SEXTON OR OTHER AUTHORITY FOR DISPOSITION

STATE OF VERMONT – AGENCY OF HUMAN SERVICES – DEPARTMENT OF HEALTH
OFFICE OF THE CHIEF MEDICAL EXAMINER
MEDICAL EXAMINER'S PERMIT TO CREMATE A DEAD HUMAN BODY

PERMIT NO. 2022c - 0006

Full name of decedent:	
Decedent's address:	
Date of death: December 29, 2022	Town of death: St. Albans City
Cause of death certified by: Donald R. Duck, M.D.	
Permission to cremate the body of this decedent at Vermont Crematory East Montpelier, VT	
Has been requested by: Joe Funeral Director	
Vermont Funeral Director License Number: 022-01234	

Being sufficiently informed as to the causes and circumstances of the death of the above described decedent, permission is hereby granted to cremate the body as requested per 18 VSA Sect. 5201 (b).

Date: December 29, 2022

Signed: (*Via the Vermont Electronic Death Registration System)*

Shapiro Signature Image

Steven L. Shapiro, MD
Chief Medical Examiner

Office of the Chief Medical Examiner
111 Colchester Ave., Baird 1
Burlington, VT 05401

Green Mountain Crematory
Northfield, Vermont

This is to certify that the body of

Name ______________________________

late of ______________________________

who died at ______________ on, ______________

at 69 years of age, was cremated at Green Mountain Crematory, Northfield, Vermont

on ______________ and in container number ______________,

[signature]
Operator in Charge of Green Mountain Crematory

The cremation burial transit permit, medical examiner's certificate and a signed cremation authorization form all prerequisite to the cremation of said body, accompanied the same.

Disposition of Cremains

Cremains were Buried on 7/14/16
scattered, buried etc. date

at Mt Calvary Town St Johnsbury
cemetery or other location

State VT signed [signature]
sexton or person making disposition

This certification may be filed with the Town Clerk in the Town where the disposition took place.

U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO. STATE FILE NO.

NAME OF DECEDENT___ For use by physician or institution

To Be Completed/ Verified By: FUNERAL DIRECTOR:

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)
2. SEX
3. SOCIAL SECURITY NUMBER

4a. AGE-Last Birthday (Years)
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF BIRTH (Mo/Day/Yr)
6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE-STATE
7b. COUNTY
7c. CITY OR TOWN
7d. STREET AND NUMBER
7e. APT. NO.
7f. ZIP CODE
7g. INSIDE CITY LIMITS? □ Yes □ No

8. EVER IN US ARMED FORCES? □ Yes □ No
9. MARITAL STATUS AT TIME OF DEATH □ Married □ Married, but separated □ Widowed □ Divorced □ Never Married □ Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)

11. FATHER'S NAME (First, Middle, Last)
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

13a. INFORMANT'S NAME
13b. RELATIONSHIP TO DECEDENT
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

14. PLACE OF DEATH (Check only one: see instructions)

IF DEATH OCCURRED IN A HOSPITAL: □ Inpatient □ Emergency Room/Outpatient □ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: □ Hospice facility □ Nursing home/Long term care facility □ Decedent's home □ Other (Specify):

15. FACILITY NAME (If not institution, give street & number)
16. CITY OR TOWN , STATE, AND ZIP CODE
17. COUNTY OF DEATH

18. METHOD OF DISPOSITION: □ Burial □ Cremation □ Donation □ Entombment □ Removal from State □ Other (Specify):
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)

20. LOCATION-CITY, TOWN, AND STATE
21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT
23. LICENSE NUMBER (Of Licensee)

To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr)
25. TIME PRONOUNCED DEAD

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)
27. LICENSE NUMBER
28. DATE SIGNED (Mo/Day/Yr)

29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month)
30. ACTUAL OR PRESUMED TIME OF DEATH
31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? □ Yes □ No

CAUSE OF DEATH (See instructions and examples)

32. 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.____________ ______

Due to (or as a consequence of):

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**

b.____________ ______

Due to (or as a consequence of):

c.____________ ______

Due to (or as a consequence of):

d.____________ ______

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

33. WAS AN AUTOPSY PERFORMED? □ Yes □ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? □ Yes □ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? □ Yes □ Probably □ No □ Unknown
36. 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
37. MANNER OF DEATH □ Natural □ Homicide □ Accident □ Pending Investigation □ Suicide □ Could not be determined

38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)
39. TIME OF INJURY
40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)
41. INJURY AT WORK? □ Yes □ No

42. LOCATION OF INJURY: State: City or Town: Street & Number: Apartment No.: Zip Code:

43. DESCRIBE HOW INJURY OCCURRED:
44. IF TRANSPORTATION INJURY, SPECIFY: □ Driver/Operator □ Passenger □ Pedestrian □ Other (Specify)

45. CERTIFIER (Check only one):
□ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
□ Pronouncing & 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.
□ Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

Signature of certifier:____________

46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32)

47. TITLE OF CERTIFIER
48. LICENSE NUMBER
49. DATE CERTIFIED (Mo/Day/Yr)
50. FOR REGISTRAR ONLY- DATE FILED (Mo/Day/Yr)

To Be Completed By: FUNERAL DIRECTOR

51. 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 or GED completed
- □ Some college credit, but no degree
- □ Associate degree (e.g., AA, AS)
- □ Bachelor's degree (e.g., BA, AB, BS)
- □ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- □ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

52. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.
- □ **No**, not Spanish/Hispanic/Latino
- □ **Yes**, Mexican, Mexican American, Chicano
- □ Yes, Puerto Rican
- □ Yes, Cuban
- □ Yes, other Spanish/Hispanic/Latino (Specify)____________

53. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
- □ White
- □ Black or African American
- □ American Indian or Alaska Native (Name of the enrolled or principal tribe)____________
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian (Specify)____________
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Pacific Islander (Specify)____________
- □ Other (Specify)____________

54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED).

55. KIND OF BUSINESS/INDUSTRY

REV. 11/2003

STATE OF VERMONT

57418

DH-PHS-DTH-89C

DEPARTMENT OF HEALTH

VERMONT CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

TYPE OR PRINT IN BLACK INK

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last)
2. SEX
3. DATE OF DEATH (Month, Day, Year)
4. SOCIAL SECURITY NUMBER
5a. AGE (Yrs.) —Last Birthday
5b. UNDER 1 YEAR — Months / Days
5c. UNDER 1 DAY — Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.)
7. BIRTHPLACE (City and State or Foreign Country)
8. PLACE OF DEATH (Check only one) — HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9. FACILITY NAME (If not institution, give street and number)
10. CITY OR TOWN OF DEATH
11. VETERAN? (If so, what war?)
12. MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify)
13. SURVIVING SPOUSE (If wife, give maiden name)
14. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do not use retired.)
15. KIND OF BUSINESS / INDUSTRY
16. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes — If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes (Specify)
18. RACE — White, Black, American Indian, etc. (Specify)
19. RESIDENCE—STATE
20. CITY, TOWN, OR LOCATION
21. MAILING ADDRESS (Street, City or Town, State, Zip Code)
22. FATHER'S NAME (First, Middle, Last)
23. MOTHER'S NAME (First, Middle, Maiden Surname)
24a. INFORMANT'S NAME (Type/Print): [illegible] Armstrong
24b. MAILING ADDRESS (Street, City, or Town, State, Zip Code)

CAUSE OF DEATH (Type or Print)

25. PART 1. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Parkinson's Disease — Approximate Interval Between Onset and Death: years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART 2. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.: Dementia

26a. WAS AN AUTOPSY PERFORMED? (Yes or No): No

26b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)

27a. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Undet. ☐ Pending
27b. DATE OF INJURY (Month, Day, Year)
27c. HOUR
27d. HOW DID INJURY OCCUR? (Enter nature of injury in Part 1 or Part 2)
27e. INJURY AT WORK (Specify Yes or No)
27f. PLACE OF INJURY At Home, Farm, Factory, Street, Office Bldg., etc. (Specify)
27g. LOCATION (Street, or R.F.D. No. / City or Town / State)

CERTIFIER

TO THE BEST OF MY KNOWLEDGE, ON THE BASIS OF THE CASE HISTORY, EXAMINATION AND/OR INVESTIGATION, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO CAUSE(S) AND MANNER STATED.

☐ Staff phys. ☒ Attend. phys. ☐ Pathologist ☐ Med. Examiner

28a. (Signature): Robert Karpimo
29a. DATE SIGNED (Mo., Day, Yr.)
29b. HOUR OF DEATH
29c. PRONOUNCED DEAD ON: (Date) (Time)
29. NAME AND ADDRESS OF CERTIFIER (Type or Print): Robert Karpimo, 1 So Prospect, Burlington, Vermont
30. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

DISPOSITION

31a. METHOD OF DISPOSITION: ☐ Temporary Storage ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
31b. PLACE OF TEMPORARY STORAGE (Cemetery, City or Town, State)
31c. PLACE OF FINAL DISPOSITION (Cemetery or Crematory, City or Town, State): Adirondack-Burlington So. Burlington, Vt.
32a. SIGNATURE OF FUNERAL DIRECTOR OR AUTHORIZED PERSON: [signature]
32b. NAME AND ADDRESS OF FACILITY OR AUTHORIZED PERSON: Ready Funeral Home, Inc., 261 Shelburne Rd Burlington, Vt. 05401
33. DATE OF DISPOSITION (Month, Day, Year): 11/16/2001
34a. REGISTRAR — Signature: [signature]
34b. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year): November 16, 2001

TO BE SIGNED BY REGISTRAR ON COPY ONLY

35a. TRUE COPY — Clerk — ATTEST: [signature]
35b. TOWN
35c. DATE (Month, Day, Year)

Clerk/Treasurer's office
Burlington, Vt.
A TRUE COPY ATTEST

2017 JAN 23 P 3:15

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE INFORMATION ON THE ORIGINAL CERTIFICATE ON FILE IN THE VERMONT DEPARTMENT OF HEALTH OR CUSTODIAL AGENCY.

[signature]

DATE ISSUED: ______________________ ATTEST:

This copy not valid unless prepared on engraved border displaying state seal of Vermont.

VERMONT CERTIFICATE OF DEATH

Aliases: None

Date of Death: [illegible] 2016 **Time of Death:** 5:30 PM **Age:** 23 Years

1442016205225
State File Number

Date of Birth: **Birthplace:** Burlington, VT **Sex:** Male

Mother's/Parent's Birth Name:

Father's/Parent's Birth Name:

Marital Status: Never married or in Civil Union **Spouse/Civil Union Partner:**

Residence:

Hispanic Origin: No **Race:** White

Occupation: [illegible] **Business/Industry:** [illegible]

Education: [illegible] credit but no degree

Ever in U.S. Armed Forces: No **Veteran of Any War:** No

Hospice Care (in past 30 days): No

Place of Death: Hospital: Emergency room/Outpatient; The University of Vermont Medical Center, Burlington, VT

Informant: [illegible] **Relationship:** [illegible]

Disposition Date: December 06, 2016 **Place of Temporary Storage:**

Method: Burial **Place of Final Disposition:**

Funeral Director/Authorized Person:

Address: [illegible], Burlington, VT 05401

Cause of Death and Interval (Onset to Death): **Manner of Death:** Natural

A. Sudden death due to

Other Contributing Conditions:

Did Tobacco Use Contribute to Death: No **Pregnant at Time of Death:** Not applicable

Date Pronounced Dead: **Time Pronounced Dead:** 5:30 PM

Medical Examiner Contacted: Yes **Autopsy Performed:** Yes

Injury Date/Time: **Injury at Work:** **Transportation Injury:**

Injury Place: **Injury Location:**

How Injury Occurred:

Medical Certifier: Elizabeth A. Bundock, MD, Office of the Chief Medical Examiner, 111 Colchester Avenue, Baird 1, Burlington, VT 05401

Title of Certifier: Medical Examiner **Date Certified:** December 02, 2016 **Other Attending Physician:**

Registration [signature] Cynthia M. Hooley, State Registrar **Date Registered:** December 02, 2016

Correction and Amendment History The following items(s) corrected/amended pursuant to 18 VSA 5202a, Attest: [signature]

Date	Item	From	Upon Application By/Per Order Of
01/04/2017	Cause of Death and Interval	A. Pending (unknown)	Elizabeth A. Bundock
01/04/2017	Manner of Death	Pending Investigation	Elizabeth A. Bundock

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE INFORMATION ON THE ORIGINAL CERTIFICATE ON FILE IN THE VERMONT DEPARTMENT OF HEALTH OR CUSTODIAL AGENCY.

DATE ISSUED: JAN 23 2017

ATTEST: [signature] Commissioner
Vermont Department of Health

This copy not valid unless prepared on engraved border displaying state seal of Vermont.

Name Known to Physician:	Date of Death:

DH-PHS-PROD-2012

STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Demographic Information

Type or Print in Black Ink

To Be Completed/Verified By: FUNERAL DIRECTOR OR PERSON ACTING AS SUCH

1a. DECEDENT'S LEGAL NAME *(First, Middle, Last, Suffix)*

1b. ALIASES *(Any other names the decedent used or was known as)* | 1c. DECEDENT'S LAST NAME AT BIRTH

2. SEX: ☐ Male ☐ Female | 3. SOCIAL SECURITY NUMBER | 4a. AGE-LAST BIRTHDAY *(Years)* | 4b. IF UNDER 1 YEAR: Months, Days | 4c. IF UNDER 1 DAY: Hours, Minutes

5. DATE OF BIRTH *(Month, Day, Year)* | 6. BIRTHPLACE *(City and State or Foreign Country - include Province if Canada)*

7a. RESIDENCE STREET AND NUMBER *(Include Apartment Number)* | 7b. CITY OR TOWN OF RESIDENCE | 7c. STATE OR FOREIGN COUNTRY

8a. EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No | 8b. VETERAN OF ANY WAR? ☐ Yes ☐ No | 8c. IF SO, WHAT WAR(S)?

9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Civil Union ☐ Widowed ☐ Divorced ☐ Civil Union dissolution ☐ Never Married or in Civil Union ☐ Unknown | 10a. BIRTH NAME OF SURVIVING SPOUSE / CIVIL UNION PARTNER | 10b. SEX OF SURVIVING SPOUSE/PARTNER ☐ Male ☐ Female ☐ Unknown

11. FATHER'S OR PARENT'S BIRTH NAME *(First, Middle, Last)* | 12. MOTHER'S OR PARENT'S BIRTH NAME *(First, Middle, Last)*

13a. INFORMANT'S NAME *(First, Middle, Last)* | 13b. RELATIONSHIP TO DECEDENT

13c. INFORMANT'S MAILING ADDRESS *(Street and Number, City or Town, State, Zip Code)*

14. DECEDENT'S EDUCATION LEVEL: *(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 or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

15. DECEDENT OF HISPANIC ORIGIN? *(Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.)*

- ☐ No, not Spanish/Hispanic/Latino/Latina
- ☐ Yes, Mexican, Mexican American, Chicano/Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino/Latina (Specify) ______

16. DECEDENT'S RACE: (*Check one or more races to indicate what the decedent considered himself or herself to be.)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) ______
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) ______
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) ______
- ☐ Other (Specify) ______

17. DECEDENT'S USUAL OCCUPATION *(Indicate type of work done during most of working life. DO NOT USE RETIRED)* | 18. KIND OF BUSINESS/INDUSTRY | 19. DID DECEDENT RECEIVE HOSPICE CARE? *(In past 30 days)* ☐ Yes ☐ No ☐ Unknown

20. PLACE OF DEATH *(Indicate only one)*
If death occurred in a hospital: ☐ Inpatient ☐ Intensive Care Unit ☐ Emergency Room/Outpatient ☐ Dead on Arrival
If death occurred somewhere other than a hospital: ☐ Nursing Home / Long Term Care Facility ☐ Hospice Facility ☐ Decedent's Home ☐ Other (specify) ______

21a. FACILITY NAME *(If not institution, give street and number)* | 21b. CITY OR TOWN | 21c. STATE

22a. METHOD OF DISPOSITION: ☐ Temporary Storage ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (specify)

22b. PLACE OF TEMPORARY STORAGE *(Name of cemetery, other place)* | 22c. LOCATION OF TEMPORARY STORAGE (*City or Town, State)*

22d. PLACE OF FINAL DISPOSITION *(Name of cemetery, crematory, other place)* | 22e. LOCATION OF FINAL DISPOSITION *(City or Town, State)*

23a. NAME OF FUNERAL FACILITY OR AUTHORIZED PERSON | 23b. ADDRESS OF FUNERAL FACILITY OR AUTHORIZED PERSON *(Street and Number, City, State, Zip Code)*

24. SIGNATURE OF FUNERAL SERVICE LICENSEE OR AUTHORIZED PERSON | 25. VERMONT LICENSE NUMBER | 26. DATE OF DISPOSITION *(Month, Day, Year)*

If attached to a completed *Preliminary Report of Death – Medical Certification*, this document shall be acceptable for issuance of burial transit and removal permits. This is not a permanent record. A town clerk may not issue certified copies of this record.

Name Known to Physician:	Date of Death:

STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Medical Certification

Type or Print in Black Ink

To Be Completed/Verified By: MEDICAL CERTIFIER

19. DID DECEDENT RECEIVE HOSPICE CARE? *(In past 30 days)* ☐ Yes ☐ No ☐ Unknown

20. PLACE OF DEATH *(Indicate only one)*
If death occurred in a hospital: ☐ Inpatient ☐ Intensive Care Unit ☐ Emergency Room/Outpatient ☐ Dead on Arrival
If death occurred somewhere other than a hospital: ☐ Nursing Home / Long Term Care Facility ☐ Hospice Facility ☐ Decedent's Home ☐ Other (specify) ____________

21a. FACILITY NAME *(If not institution, give street and number)*	21b. CITY OR TOWN	21c. STATE

27. MANNER OF DEATH: *Note: All deaths that are not "Natural" should be referred to a Medical Examiner. Call 1-888-552-2952.*
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could Not Be Determined

28. CAUSE **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. ____________________ ________
Due to (or as a consequence of):

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.***

b. ____________________ ________
Due to (or as a consequence of):

c. ____________________ ________
Due to (or as a consequence of):

d. ____________________ ________

29. CAUSE **PART II.** *Enter other significant conditions contributing to death but not resulting in the underlying cause given in* ***PART I.***

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE:
☐ Yes ☐ Probably ☐ No ☐ Unknown	☐ 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

32a. WAS MEDICAL EXAMINER CONTACTED?	32b. M.E. CASE NUMBER	33. WAS AN AUTOPSY PERFORMED?	34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH?
☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

IF AN INJURY IS PART OF THE CAUSE OF DEATH [illegible] OR IF THE DEATH SHOULD BE CERTIFIED BY A MEDICAL EXAMINER. CALL 1-888-[illegible]

35. DATE OF INJURY *(Month, Day, Year)*	36. TIME OF INJURY	37. PLACE OF INJURY *(e.g. Decedent's home, construction site, restaurant, wooded area)*	38. INJURY AT [illegible]
	☐ AM ☐ PM		☐ Yes ☐ No

39. LOCATION OF INJURY *(Street and Number, City or Town, State)*

40. DESCRIBE HOW INJURY OCCURRED	41. IF TRANSPORTATION INJURY, SPECIFY:
	☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (specify) ________

42a. ACTUAL OR PRESUMED DATE OF DEATH *(Month, Day, Year)*	42b. ACTUAL OR PRESUMED TIME OF DEATH	42c. DATE PRONOUNCED DEAD *(Month, Day, Year)*	42d. TIME PRONOUNCED DEAD
	☐ AM ☐ PM		☐ AM ☐ PM

43a. SIGNATURE OF CERTIFIER – To the best of my knowledge, on the basis of case history, examination, and/or investigation, death occurred at the time, date, and place and due to the cause(s) and manner stated.	43b. DATE CERTIFIED *(Month, Day, Year)*

43c. NAME OF CERTIFIER *(Type or Print)*	43d. LICENSE NUMBER

43e. ADDRESS OF CERTIFIER *(Street and Number, City or Town, State, Zip Code)*	44. CONTACT PHONE NUMBER
	( )

45. TITLE OF CERTIFIER:	46. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER *(Type or Print)*
☐ Physician ☐ Pathologist ☐ Medical Examiner ☐ Physician Assistant ☐ Advanced Practice Registered Nurse	

If attached to a completed *Preliminary Report of Death – Demographic Information*, this document shall be acceptable for issuance of burial transit and removal permits. This is not a permanent record. A town clerk may not issue certified copies of this record.

DEPARTMENT OF HEALTH
VERMONT RECORD OF DIVORCE OR ANNULMENT

Docket # 45-2-16 Frdm

Dept. of Health Use ONLY
State File # ______

APPLICANT A ☐ HUSBAND ☒ WIFE ☐ SPOUSE (Check one)

1a. Name (First, Middle, Last)	1b. Last Name at Birth	1c. Sex
		☐ Female ☐ Male

2a. State of Residence	2b. City or Town of Residence	3. Date of Birth (month, day, year)
		/ /

APPLICANT B ☒ HUSBAND ☐ WIFE ☐ SPOUSE (Check one)

4a. Name (First, Middle, Last)	4b. Last Name at Birth	4c. Sex
		☐ Female ☐ Male

5a. State of Residence	5b. City or Town of Residence	6. Date of Birth (month, day, year)
		/ /

MARRIAGE

7a. State or foreign country of this marriage	7b. City or Town of this marriage	7c. Date of this marriage (month, day, year)
Vermont	St Albans	

8a. Date couple last resided in same household (month, day, year)	8b. Number of children under 18 in this household as of the date in item 8a.
/ /	NONE

9a. Name of Petitioner's Attorney	9b. Attorney's Address (street, city/town, state, zip)
☒ NO ATTORNEY	

DECREE

10. I certify that this decree became absolute (final) on (month, day, year)	11. Type of decree (check one)	12. County of decree
11 / 22 / 2016	☒ Divorce ☐ Annulment	FRANKLIN

13. Legal grounds for decree *(specify)*	14. Court Manager's Name	15. Date signed (month, day, year)
Parties have lived separate in excess of 6 consecutive months	[signature]	12 / 14 / 16

9/09 SML

VDH-VR-DIV-9/2009

STATE OF VERMONT

DEPARTMENT OF HEALTH
VERMONT RECORD OF DIVORCE OR ANNULMENT

Docket #: [illegible]

Dept. of Health Use ONLY
State File #: [illegible]

APPLICANT A ☒ HUSBAND ☐ WIFE ☐ SPOUSE (Check one)

1a. Name (First, Middle, Last)	1b. Last Name at Birth	1c. Sex ☐ Female ☐ Male

2a. State of Residence	2b. City or Town of Residence	3. Date of Birth (month, day, year)
Vermont		

APPLICANT B ☐ HUSBAND ☒ WIFE ☐ SPOUSE (Check one)

4a. Name (First, Middle, Last)	4b. Last Name at Birth	4c. Sex ☒ Female ☐ Male

5a. State of Residence	5b. City or Town of Residence	6. Date of Birth (month, day, year)

MARRIAGE

7a. State or foreign country of this marriage	7b. City or Town of this marriage	7c. Date of this marriage (month, day, year)

8a. Date couple last resided in same household (month, day, year)	8b. Number of children under 18 in this household as of the date in Item 8a.
	None

9a. Name of Petitioner's Attorney	9b. Attorney's Address (street, city/town, state, zip)
☒ NO ATTORNEY	

DECREE

10. I certify that this decree became absolute (final) on (month, day, year)	11. Type of decree (check one)	12. County of decree
05 / 03 / 2016	☒ Divorce ☐ Annulment	Windsor

13. Legal grounds for decree (specify)	14. Court Manager's Name	15. Date signed (month, day, year)
6+ mos separation	Andrew Stone	05 / 06 / 2016

9/09 SML

VDH-VR-DIV-9/2009

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE INFORMATION ON THE ORIGINAL CERTIFICATE ON FILE IN THE VERMONT DEPARTMENT OF HEALTH OR CUSTODIAL AGENCY.

DATE ISSUED: JAN 23 2017

ATTEST: Commissioner
Vermont Department of Health

This copy not valid unless prepared on engraved border displaying state seal of Vermont.

ANY ALTERATION OR ERASURE

DH-PHS-MARAPP-2012

VERMONT DEPARTMENT OF HEALTH

APPLICATION FOR VERMONT LICENSE OF CIVIL MARRIAGE

FEE FOR CIVIL MARRIAGE LICENSE $45.00

APPLICANT A ☐ BRIDE ☐ GROOM ☐ SPOUSE (check one)

1a. LEGAL NAME (First, Middle, Last)	**1b. LAST NAME AT BIRTH** (Maiden Surname)

2. SEX	**3. DATE OF BIRTH** (Month, Day, Year)	**4. BIRTHPLACE** (State or Foreign Country)

5a. RESIDENCE ADDRESS (Number and Street)	**5b. CITY OR TOWN OF RESIDENCE**
5c. STATE OF RESIDENCE	**5d. COUNTRY OF RESIDENCE**
6a. FATHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)	**6b. BIRTHPLACE** (State or Foreign Country)
7a. MOTHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)	**7b. BIRTHPLACE** (State or Foreign Country)

APPLICANT B ☐ BRIDE ☐ GROOM ☐ SPOUSE (check one)

8a. LEGAL NAME (First, Middle, Last)	**8b. LAST NAME AT BIRTH** (Maiden Surname)

9. SEX	**10. DATE OF BIRTH** (Month, Day, Year)	**11. BIRTHPLACE** (State or Foreign Country)

12a. RESIDENCE ADDRESS (Number and Street)	**12b. CITY OR TOWN OF RESIDENCE**
12c. STATE OF RESIDENCE	**12d. COUNTRY OF RESIDENCE**
13a. FATHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)	**13b. BIRTHPLACE** (State or Foreign Country)
14a. MOTHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)	**14b. BIRTHPLACE** (State or Foreign Country)

THE CONFIDENTIAL INFORMATION BELOW MUST BE COMPLETED. IT WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD.

APPLICANT A

22. TOTAL NO. OF MARRIAGES AND CIVIL UNIONS, INCLUDING THIS ONE	**23a. LAST MARRIAGE OR CIVIL UNION ENDED BY** (check one)	**23b. DATE LAST MARRIAGE OR CIVIL UNION ENDED**
	___ Death ___ Divorce ___ Dissolution ___ Annulment ___ Civil union did not end; marrying civil union partner	Month ____________ Year ______

APPLICANT B

25. TOTAL NO. OF MARRIAGES AND CIVIL UNIONS, INCLUDING THIS ONE	**26a. LAST MARRIAGE OR CIVIL UNION ENDED BY** (check one)	**26b. DATE LAST MARRIAGE OR CIVIL UNION ENDED**
	___ Death ___ Divorce ___ Dissolution ___ Annulment ___ Civil union did not end; marrying civil union partner	Month ____________ Year ______

DOES EITHER APPLICANT HAVE A LEGAL GUARDIAN? ____YES ____ NO

18 V.S.A. § 5131 (4)(A) provides that "parties to a civil union certified in Vermont may elect to dissolve their civil union upon marrying one another but are not required to do so to form a civil marriage." The option to elect dissolution of the civil union is found in the confidential section of the marriage license and shall become effective upon solemnization of the marriage.

APPLICANTS

We/I hereby certify that the information provided is correct to the best of our/my knowledge and belief and that we are free to marry under the laws of Vermont.

15a. SIGNATURE (Applicant A)	**15b. DATE SIGNED**	**16a. SIGNATURE** (Applicant B)	**16b. DATE SIGNED**
15c. TELEPHONE NUMBER	**15d. E-MAIL ADDRESS**	**16c. TELEPHONE NUMBER**	**16d. E-MAIL ADDRESS**

Planned marriage date ____________________ Location (City or Town) ____________________

Officiant name and mailing address ____

Your mailing address after wedding ____

Do you want a certified copy of your Civil Marriage Certificate ($10.00) _____ Yes _____ No

Date license issued ____________________ Clerk issuing license ____________________

THIS WORKSHEET MAY BE DESTROYED AFTER CIVIL MARRIAGE IS REGISTERED

DH-PHS-MARLIC-2012

201600012
LOCAL FILE NUMBER

DEPARTMENT OF HEALTH
VERMONT LICENSE AND CERTIFICATE OF CIVIL MARRIAGE

STATE FILE NUMBER

TYPE OR PRINT IN BLACK INK

APPLICANT A [ ] BRIDE [X] GROOM [ ] SPOUSE (check one)

1a. LEGAL NAME (First, Middle, Last)		1b. LAST NAME AT BIRTH (Maiden Surname)
2. SEX	3. DATE OF BIRTH (Month, Day, Year)	4. BIRTHPLACE (State or Foreign Country)
5a. RESIDENCE ADDRESS (Number and Street)		5b. CITY OR TOWN OF RESIDENCE
5c. STATE OF RESIDENCE		5d. COUNTRY OF RESIDENCE
6a. FATHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)		6b. BIRTHPLACE (State or Foreign Country)
7a. MOTHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)		7b. BIRTHPLACE (State or Foreign Country)

APPLICANT B [X] BRIDE [ ] GROOM [ ] SPOUSE (check one)

8a. LEGAL NAME (First, Middle, Last)		8b. LAST NAME AT BIRTH (Maiden Surname)
9. SEX	10. DATE OF BIRTH (Month, Day, Year)	11. BIRTHPLACE (State or Foreign Country)
12a. RESIDENCE ADDRESS (Number and Street)		12b. CITY OR TOWN OF RESIDENCE
12c. STATE OF RESIDENCE		12d. COUNTRY OF RESIDENCE
13a. FATHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)		13b. BIRTHPLACE (State or Foreign Country)
14a. MOTHER'S OR PARENT'S NAME (First, Middle, Last Name at Birth)		14b. BIRTHPLACE (State or Foreign Country)

We/I hereby certify that the information provided is correct to the best of our/my knowledge and belief and that we are free to marry under the laws of Vermont.

15a. SIGNATURE (Applicant A)	15b. DATE SIGNED	16a. SIGNATURE (Applicant B)	16b. DATE SIGNED

CERTIFICATION I hereby certify that the above named persons have made oath to the truth of the facts stated in the foregoing declaration of intention of marriage and complied with the marriage laws of the State of Vermont.

OFFICIANT (See instructions on back) This license authorizes the marriage IN VERMONT ONLY of the above named parties by any person duly authorized to perform a marriage.

17a. DATE ON WHICH LICENSE WAS ISSUED (Month, Day, Year): March 3, 2016	18a. I CERTIFY THAT THE ABOVE PERSONS WERE MARRIED ON (Month, Day, Year)	18b. WHERE MARRIED - CITY OR TOWN
17b. TOWN CLERK (Signature): [signature] Asst	18c. SIGNATURE OF PERSON PERFORMING CEREMONY	18d. TITLE
17c. TOWN OR CITY: Town of Bennington	18e. NAME (Type/Print)	18f. TELEPHONE NUMBER
17d. THIS LICENSE IS VALID FROM March 3, 2016 (DATE) TO May 2, 2016 (DATE)	18g. MAILING ADDRESS OF PERSON PERFORMING CEREMONY (Number and Street, City or Town, State, Zip Code)	

REGISTRATION

19a. CLERK'S SIGNATURE: [signature]	19b. DATE RECEIVED BY LOCAL REGISTRAR: March 3, 2016	
20a. TRUE COPY - (Clerk's Signature) ATTEST:	20b. TOWN: Town of Bennington	20c. DATE