1.1	LOCAL	-
A 3.4	LOCAL	٠

CH		1. CHILD'S NAME (First, Middle, Last, Suffix)			2. TIME OF BIRTH (24 hr)		E OF BIRTH (Mo/Day
		5. FACILITY NAME (If not institution, give street and	number) E	B. CITY, TOWN, OR LO	CATION OF BIRTH	7. COUNTY OF	BIRTH
МО	THER	8a. MOTHER'S CURRENT LEGAL NAME (First, I	Middle, Last, Suffix)	8b. D	ATE OF BIRTH (Mo/Day	Yŋ	
		BC. MOTHER'S NAME PRIOR TO FIRST MARRI	AGE (First, Middle, Last, Suffix)	8d. B	IRTHPLACE (State, Ter	ritory, or Foreign Co	untry)
		9a, RESIDENCE OF MOTHER-STATE 9b.	COUNTY	96.	CITY, TOWN, OR LOC	ATION	
	•	9d. STREET AND NUMBER		Se. APT. NO.	9f. ZIP CODE		9g. INSIDE CIT LIMITS? D Yes D N
FA	THER	10a. FATHER'S CURRENT LEGAL NAME (First,	Middle, Last, Suffix)	05. DATE OF BIRTH (	Mo/Day/Yr) 10c. Bif	THPLACE (State, Te	anitory, or Foreign Count
CER	TIFIER	11. CERTIFIER'S NAME: TITLE: DMD DO DHOSPITAL ADMIN.		12: DATE CE	RTIFIED	13. DATE FILED	BY REGISTRAR
		OTHER (Specify)			ם איזיי	MM DD	<b>YYYY</b> <sup>5</sup>
MO	THER	14. MOTHER'S MAILING ADDRESS: 9 Same	INFORMATION FOR ADMINISTR as residence, or: State:	RATIVE USE	City, Town, or Locati	oņ:	
		Street & Number.	P2 3		Apartment No.:		Zip Code:
		15. MOTHER MARRIED? (At birth, conception, or a IF NO, HAS PATERNITY ACKNOWLEDGEME			FOR CHILD?		D 17. FACILITY ID. (
	7	18 MOTHER'S SOCIAL SECURITY NUMBER:		19. FATHER'S	SOCIAL SECURITY N	UMBER:	
MO	THER	20. MOTHER'S EDUCATION (Check the	21. MOTHER OF HISPANIC ORI	GIN? (Check	22. MOTHER'S RA		
		box that best describes the highest degree or level of school completed at the time of delivery)	the box that best describes w mother is Spanish/Hispanic/Le "No" box if mother is not Spar	atina. Check the	what the mother	considers herself t American	o be)
		8th grade or less	No, not Spanish/Hispanic/Lat	ina	American India (Name of the eigenversion)	n or Alaska Native volled or principal tri	be)
		□ 9th - 12th grade, no diploma	Yes, Mexican, Mexican Amer	ican, Chicana	Asian Indian Chinese		
		High school graduate or GED     completed	Yes, Puerto Rican		🗆 Filipino		
		<ul> <li>Some college credit but no degree</li> </ul>	📋 Yes, Cuban		<ul> <li>Japanese</li> <li>Korean</li> </ul>		
			Yes, other Spanish/Hispanic/	Latina	🗆 Vietnamese		
<u></u>		Associate degree (e.g., AA, AS)	(Specify)		Other Asian (Sp Native Hawailar		
فلمنت		Bachelor's degree (e.g., BA, AB, BS)			Guamanian or 0		
		Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)			Samoan     Other Pacific Ist	ender (Specific)	
		<ul> <li>Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)</li> </ul>			Other (Specify)		·····
A	<u>r(:) z r</u> y	<ol> <li>FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)</li> </ol>	24. FATHER OF HISPANIC ORIC the box that best describes wi father Is Spanish/Hispanic/Lat "No" box if father is not Spani	nether the ino, Check the	25. FATHER'S RAC what the father	E (Check one or mo considers himself to	
	1	<ul> <li>8th grade or less</li> </ul>	No, not Spanish/Hispanic/Lat	ino	Black or Africar		
		9th - 12th grade, no diploma	🗆 Yes, Mexican, Mexican Amer	ican, Chicano	<ul> <li>American India (Name of the example</li> </ul>	n or Alaska Native nrolled or principal tri	be)
	P I	High school graduate or GED	Yes, Puerto Rican		<ul> <li>Asian Indian</li> <li>Chinese</li> </ul>		
	Medical Record	completed	Yes, Cuban		D Chinese		- Yer-
i	Ř	Some college credit but no degree	Yes, other Spanish/Hispanic/	Latino	<ul> <li>Japanese</li> <li>Korean</li> </ul>		
<u>e</u>	lica	🗖 Associate degree (e.g., AA, AS)	(Specify)		Vietnamese		
an	led	Bachelor's degree (e.g., BA, AB, BS)	~		<ul> <li>Other Asian (Sp</li> <li>Native Hawaiian</li> </ul>	*/	
N S		Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)			🗆 Guamanian or C		
er	je l	Doctorate (e.g., PhD, EdD) or			Other Pacific Isl	ander (Specify)	
Mother's Name	Mother's No.	Professional degrée (e.g., MD, DDS, DVM, LLB, JD)			□ Other (Specify)		
r		26. PLACE WHERE BIRTH OCCURRED (Check	one) 27. ATTENDANT'S NAME,	, TITLE, AND NPI		HER TRANSFERRE	
		Hospital     Freestanding birthing center	NAME:	NPI:	DEL	/ERY? D Yes D	No
		<ul> <li>Home Birth: Planned to deliver at home? 9 Yes</li> <li>Clinic/Doctor's office</li> </ul>				S, ENTER NAME O ISFERRED FROM:	F FACILITY MOTHER
		Child/Doctor's office     Other (Specify)	OTHER (Specify)				
REV. 11/20	003		L		L	· · · · · · · · · · · · · · · · · · ·	· · · · ·

NM       D       VYY       M       D       VYY       D       Comparing the second s	MOTHER	29a. DATE OF FIRST PRENATAL CA	RE VISIT No Prenatal Care	29b. DATE O	LAST PRENATAL CARE VISIT	. TOTAL NUM	BER OF PRENATA	L VISITS FOR THIS PREGNANCY
(Perforder)     (Perfor)     (Perforder)     (Perforder)     (Perforder)     (Perforder)	the second s		<u>^</u>			<u> </u>		· · · · · · · · · · · · · · · · · · ·
Live BitTris Do names in a set of the method of genesis and the m						AT DELIVERY		
35.         Note Ling         Site Note Ling         Average number of digenets or products of digenets in the digenets or products of digenets or products or p		LIVE BIRTHS (Do not Include	PREGNANCY (spontaneous of	OUTCOMES or induced	For each time period, enter eithe	rthe number o	f cigarettes or the	PAYMENT FOR THIS
Numbra         Numbra<		35a. Now Living 35b. Now Dead			Average number of cigarettes or pa	icks of cigarett	es smoked per day. # of packs	
Constant of Page 20 Marker of Page 20 Marke	- · · ·	Number Number	Number		First Three Months of Pregnancy	- p- 1 A	OR	⊡ Self-pay
Mail         VVVV         Mail         DD           Mail         VVVV         Mail         DD         VVVV           MEDICAL AND Deters         1, REST, pictor GR in THP REGUNACY Deters         VVVV         VVVV         VVVV           Departmentary (Disputs protes the program of the pr		🗆 None 🗆 None	🖬 None			≫ <u></u>		
MM     VVVY     MM     DD     VVVY       MM     DD     VVVY       MM     DD     VVVY       MM     DD     VVVY       MND     DEatestance     Additional and paper       Debatestance     Constrained paper    <	а. До се	35c. DATE OF LAST LIVE BIRTH			39. DATE LAST NORMAL MENSE	S BEGAN	40. MOTHER'S M	EDICAL RECORD NUMBER
AND       Discussion (Charled in the graph)         AND       C detational (Charled in the graph)         FORMATION       C detational (Charled in the graph)         VF ORMATION       C detational (Charled in the graph)         C detational (Charled in the graph)       C detational (Charled in the graph)         C detational (Charled in the graph)       C detational (Charled in the graph)         C detational (Charled in the graph)       C detational (Charled in the graph)         C detational (Charled in the graph)       C detational (Charled in the graph)         C detational (Charled in the graph)       C detational (Charled in the graph)         C detational (Charled in the graph)       C detational (Charled in the detation (Charled in the detation (Charled in the detation (Charled in the detational (Charled in the detation (Charled in the detatio	. •	MM YYYY	/////////////_/		MM DD YYYY	- ,		
AND Preparations (Clapped prior to this programs) HEALTH PORMATION Provide and the programs) PORMATION Provide and the programs) PORMATION Provide and the programs) Portune and the programs) Portune and the programs) Provide and the programs (Clapped prior to this programs) Portune and the programs (Clapped prior to the programs) Provide prior the programs (Clapped prior to the programs) Provide prior to the programs (Clapped prior to the programs) Provide prior the programs (Clapped prior to the programs) Provide prior to the programs (Clapped prior to the programs) Provide prior the programs (Clapped prior to the programs) Provide prior to the programs (Clapped prior to the programs) Provide prior to the programs (Clapped prior to the programs) Provide prior to the programs (Clapped prior to the programs) Provide prior to the programs (Clapped prior to the programs) Provide provide cancel and prior to the programs (Clapped prior to the programs) Provide provide cancel and the programs (Clapped prior to the programs) Provide provide cancel and the programs (Clapped prior to the programs) Provide provide cancel and the programs (Clapped prior to the programs) Programs (Clapped prior to the programs) Provide provide cancel and the programs (Clapped prior to the programs) Programs (Clapped prior to the prior to the prior to the programs) Programs (Clapped prior to the programs)	MEDICAL		NCY	43. (OBSTET	RIC PROCEDURES (Check all that a	pply)	46. METHOD OF	DELIVERY
FIELALTH       C Setadowall       (Departing of Characteria in the program of the active setatory in the program of the active setatory in the program of the active setatory in the active set active setatory in the active set active set active setatory in the active set acti								
VEV DRM AT TON:       Preparations       0       Security of the sec	HEALTH	<ul> <li>Prepregnancy (Diagnosis prior</li> <li>Gestational (Diagnosis in thi</li> </ul>	to this pregnancy) s pregnancy)					
Castalgoist (PT) processing and Castalgoist (PT) processing and Castalgoist (PT) processing and Castalgoist (PT) (PT) (PT) (PT) (PT) (PT) (PT) (PT)	NFORMATION		.4				B. Was delivery w	ith vacuum extraction attempted
Campels     C	· · · · · · · ·			D Failed				
	يتناق يعامي ي		-y	D None of t	he above		C. Fetal presenta	tion at birth
Contrar providing conjunction generation and providence of the second seco		Previous preterm birth		44. ONSET (	OF LABOR (Check all that apply)		Cephalic	
Precipious Labor (-2 hrs.)		Other previous poor pregnancy out	come (Includes			ad 312 hrs )		2
Decay and a series of the above and a s		perinatal death, small-for-gestation		10				
			reatment-If ves					
Intradiction teaching of the electrology (e.g., in vito for distance decording (e.g., in vito for distance electrology (e.g., in vito) for distance electrology (e.g., i		check all that apply:	,			. • · ·	□ Vaginal/Va	icuum 🦼 🔬
fertilization (VP): gamele intradisiopian transfer (GFT)       0. Kondex intradisiopian (Christia units apply)       0. Kondex intradisiopian (Christia units apply)       0. Kondex intradisiopian (Christia units apply)         0. Monter had a previous casarean delivery (Figs. how many (Figs. how m		Intrauterine insemination			e above		If cesarean	
Molifer had a previous cesamen delivery If yes, how many		fertilization (IVF), gamete intrafa	allopian	45. CHARACI		₹Y		· · ·
Augmentation of tigber     Augmentation of tigger     Augmentation of	•			D Induction	f labor		47. MATERNAL (Complication	MORBIDITY (Check all that apply)
<ul> <li>None of the above</li> <li>Storoids (glucociticids) by the mother prior to delivery</li> <li>Infections Present ANDOR TREATED</li> <li>DURING THIS PREGNANCY (Check all that apply)</li> <li>Antibiolics recaived by the mother prior to delivery</li> <li>Antibiolics recaived by the mother prior to delivery</li> <li>Chical choroamicnitis diagnosed during labor</li> <li>Dipagmed hystersciony</li> <li>Chical choroamicnitis during labor</li> <li>Dipagmed hystersciony</li> <li>None of the above</li> <li>Dipagmed hystersciony</li> <li>None of the above</li> <li>NewBOR N INFORMATION</li> <li>Stantwellow antibility of the bab hystersciony</li> <li>Assisted ventilation required immediately following dalivery</li> <li>Assisted ventilation required for more than ashoura</li> <li>Stapedid drophysterece</li></ul>			elivery	a Augmenta	tion of labor		delivery)	
42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)       Interview day the mother during labor or matismal temperature 23°C (100 4°F)       Interview day the mother during labor or matismal temperature 23°C (100 4°F)         Genorthea       Syphilis       Interview day the mother during labor or matismal temperature 23°C (100 4°F)       Admission to interview care unit following actions was taken. In-ution resuscitative measures, there feat assessment, or operative delivery       Admission to interview care unit following actions was taken. In-ution resuscitative measures, there feat assessment, or operative delivery       None of the above         NEWBORN       F48. Integrature of tabor such that, or operative delivery       St. ADMOMALIES OF THE NEWBORN (Check all that apply)       None of the above         49. BIRTHWEIGHT (grams preferred, specify unit)       54. ADMORMAL CONDITIONS OF THE NEWBORN (Check all that apply)       St. CONSENTIAL ANOMALIES OF THE NEWBORN (Check all that apply)       Anancophaly         49. BIRTHWEIGHT (grams preferred, specify unit)       54. ADMORMAL CONDITIONS OF THE NEWBORN (Check all that apply)       Anancophaly         50. OBSTETRICESTIMATE OF GESTATION: (completed weeks)       NICU admission       St. Assisted ventilation required for more than shores       NICU admission         51. APGAR SCORE: Sore at 10 minutes: (Specify)       Newborn given surfactant replacement thores;       Newborn given surfactant replacement thores;       Stayphyse confirmed Difference         52. PLURALITY - Single, Twin, Triplet, etc.       Stayphyse printing P		None of the above		Steroids (	lucocorticolds) for fetal lung maturation	n	二 二 二 二 二 キャド・トキット	
Conorthea     Syphilis     Chlanydia     Chlanydia     Chlanydia     Hepatits C     Hepatits C     None of the above     NeWBORN INFORMATION     NewBORN     Ne		42. INFECTIONS PRESENT AND/OI						
Syphilis     Chamydia						or	D Admission t	o intensive care unit
Image: Second		Syphilis		D Moderate/	heavy meconium staining of the amni		following de	livery
Image: Big in the second se			<b>`</b>	following	actions was taken: in-utero resuscita	tive	D None of the	above
None of the above         NewBorn INFORMATION         NEWBORN INFORMATION         48. NEWBORN MEDICAL RECORD NUMBER         49. BIRTHWEIGHT (grams preferred, specify unit)         50. OBSTETRIC ESTIMATE OF GESTATION:		D Hepatitis C				ve delivery	÷.	
NEWBORN       48. NEWBORN MEDICAL RECORD NUMBER       54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that epply)       55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that epply)         49. BIRTHWEIGHT (grams preferred, specify unit)       Assisted vantilation required immediately following delivery       Assisted vantilation required immediately following delivery       Maningomyelocele/Spina biffda         9 grams       9 bi/oz       Assisted vantilation required for more than six hours       Congenital diaphragmatic hernia         50. OBSTETRIC ESTIMATE OF GESTATION: 		None of the above						
NEWBORN       48. NEWBORN MEDICAL RECORD NUMBER       54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that epply)       55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that epply)         49. BIRTHWEIGHT (grams preferred, specify unit)       Assisted vantilation required immediately following delivery       Assisted vantilation required immediately following delivery       Anencephaly       Anencephaly         9 grams       9 lb/dz       Assisted vantilation required for more than six hours       Congenital disparagetic herrita amputation and dwarfing syndromes)         50. OBSTETRIC ESTIMATE OF GESTATION: 					1977 - 2019 1			· ·
NEWBORN       48. NEWBORN MEDICAL RECORD NUMBER       54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that epply)       55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that epply)         49. BIRTHWEIGHT (grams preferred, specify unit)       Assisted vantilation required immediately following delivery       Assisted vantilation required immediately following delivery       Maningomyelocele/Spina biffda         9 grams       9 bi/oz       Assisted vantilation required for more than six hours       Congenital diaphragmatic hernia         50. OBSTETRIC ESTIMATE OF GESTATION: 								
NEWBORN       48. NEWBORN MEDICAL RECORD NUMBER       54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)       55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)         49. BIRTHWEIGHT (grams preferred, specify unit)       Assisted vantilation required immediately following delivery       Assisted vantilation required immediately following delivery       Anencephaly         9 grams       9 lb/oz       Assisted vantilation required for more than six hours       Congenital heard disease         50. OBSTETRIC ESTIMATE OF GESTATION: 								
NEWBORN       48. NEWBORN MEDICAL RECORD NUMBER       54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)       55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)         49. BIRTHWEIGHT (grams preferred, specify unit)       48. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)       56. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)         9 grams       9 lb/dz       Assisted vantilation required immediately following delivery       Assisted vantilation required for more than six hours       56. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)         50. OBSTETRIC ESTIMATE OF GESTATION: 					· · · ·			
49. BIRTHWEIGHT (grams preferred, specify unit)       Assisted vantilation required immediately       Anencephaly         9 grams       9 lb/oz       Cyanotic congenital heart disease         50. OBSTETRIC ESTIMATE OF GESTATION:       Assisted ventilation required for more than six hours       Congenital diaphragnatic herria         50. OBSTETRIC ESTIMATE OF GESTATION:       NICU admission       Congenital diaphragnatic herria         61. APGAR SCORE:       NICU admission       Cleft Lip with or without Cleft Palate         Score at 10 minutes:       Antiblotics received by the newborn for suspected neonatal sepsis       Suspected neonatal sepsis         Score at 10 minutes:       Seizure or serious neurologic dysfunction       Suspected neonatal sepsis         Score at 10 minutes:       Significant birth injury (skelatal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemomrage       Suspected organ and memorinage						55.00		
Assisted ventilation required immediately following delivery     Assisted ventilation required immediately following delivery     Assisted ventilation required immediately following delivery     Assisted ventilation required for more than six hours     NECU admission     Newborn given surfactant replacement therapy     Score at 5 minutes:     Antiblotics received by the newborn for suspected neonatal sepsis     Score at 10 minutes:	NEWBORN						(Check all t	
9 grams       9 grams       9 lb/oz <ul> <li>Assisted ventilation required for more than six hours</li> <li>Congenital diaphragnetic herria</li> <li>Congenital diaphragnetic herria</li></ul>		49. BIRTHWEIGHT (grams preferred, s	specify unit)					na bifida
50. OBSTETRIC ESTIMATE OF GESTATION: <ul> <li>Assisted ventilation required for more than six hours</li> <li>Omphalocale</li> <li>Gastryschisis</li> <li>Ilmb reduction defect (excluding congenital amputation and dwarfing syndromes)</li> <li>Cleft Lp with or without Cleft Palate</li> <li>Down Syndrome</li> <li>Karyotype pending</li> </ul> 50. OBSTETRIC ESTIMATE OF GESTATION: <ul> <li>Newborn given surfactant replacement</li> <li>therapy</li> <li>Cleft Lp with or without Cleft Palate</li> <li>Down Syndrome</li> <li>Karyotype pending</li> <li>Score at 10 minutes:</li> <li>Secure or serious neurologic dysfunction</li> <li>Karyotype pending</li> <li>Suspected chromosonal disorder</li> <li>Karyotype pending</li> <li>Karyotype pending</li> <li>Karyotype pending</li> <li>Hypospadias</li> <li>More of the sonomatias</li> <li>Hypospadias</li> <li>Hypospadias</li> <li>Hypospadias</li> </ul>		9 grams 9 lb/oz			- •			
Image: Completed weeks)       Image: NICU admission         Image: Completed weeks)       Newborn given surfactant replacement therapy         Image: Completed weeks)       Image: Nicutation admitted weeks         Image: Completed weeks)       Image: Completed weeks         Image: Completed weeks       Image: Completed weeks		50 OBSTETRIC ESTIMATE OF GEST			tion required for more than	u On	nphalocele	
51. APGAR SCORE: <ul> <li>Newborn given surfactant replacement therapy</li> <li>Cleft Lip with or without Cleft Palate</li> <li>Cleft Palate alone</li> <li>Down Syndrome</li> <li>Cleft Palate alone</li> <li>Down Syndrome</li> <li>Karyotype confirmed</li> <li>Karyotype pending</li> </ul> <li>Score at 10 minutes:</li> <li>Significant birth injury (skelatal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage</li> <li>Hypospadias</li>		•		NICLI admission	1		nb reduction defect (	
51. APGAR SCORE:       □ Cleft Palate alone         Score at 5 minutes:       □ Antibiotics received by the newtrom for suspected neonatal sepsis       □ Down Syndrome         If 5 minutes:       □ Antibiotics received by the newtrom for suspected neonatal sepsis       □ Karyotype confirmed         Score at 10 minutes:       □ Seizure or serious neurologic dysfunction       □ Karyotype confirmed         S2. PLURALITY - Single, Twin, Triplet, etc.       □ Significant birth injury (skelatal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage       □ Nona of the sonometer series		(completed #	,					
PC       Score at 10 minutes <ul> <li>Antibiotics received by the newborn for suspected neonatal sepsis</li> <li>Score at 10 minutes</li> <li>Secure or serious neurologic dysfunction</li> <li>Secure</li></ul>		51. APGAR SCORE:			surraciant replacement		aft Palate alone	
Score at 10 minutes:								ed
O       Seizure or serious neurologic dysfunction         Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)       Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)       Hypospadias         Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)       None of the anomalies listed above         Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)       None of the anomalies listed above         Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)       None of the anomalies listed above         Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)       None of the anomalies listed above         Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage       None of the anomalies listed above         Significant birth injury (status)       9 None of the above       Significant birth injury (status)         Significant birth injury (status)       9 None of the above       Significant birth injury (status)         Significant birth injury (status)       9 None of the above       Significant birth injury (status)	P			•				
a       b       FLURALLY - Single, Iwin, Triplet, etc.       C Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)       Hypospadias         b       53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)       9 None of the above       None of the anomalies listed above         s       s       s       s       s       s       s       s         s       s       is       is       s       s       s       s         s       s       s       s       s       s       s       s         s       s       s       s       s       s       s       s         s       s       s       s       s       s       s       s         s       s       s       s       s       s       s       s         s       s       s       s       s       s       s       s         s       s       s       s       s       s       s       s       s         s       s       s       s       s       s       s       s       s       s       s       s       s       s       s	ecc			Seizure or serio	us neurologic dysfunction		Karyotype confirm	ed
Image: Second and Solution Solutis Solution Solution Solution Solution Solution Solution Solution	Ĩ Ř		etc.			+;	ypospadias	i de la companya de l
Find       Bit in the bit rest of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: State of the showe       Image: State of the showe         Image: St	lica		st Second					listed above
Signature       9 None of the above         9 None of the above       9 None of the above         9 None of the above       56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No         57. IS INFANT LIVING AT TIME OF REPORT?       58. IS THE INFANT BEING         16 Yes, NAME OF FACILITY INFANT TRANSFERRED       9 Yes 9 No         170       16 Yes, NAME OF FACILITY INFANT TRANSFERRED	Med		· ·					
56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No 57. IS INFANT LIVING AT TIME OF REPORT? 58. IS THE INFANT BEING IF YES, NAME OF FACILITY INFANT TRANSFERRED C 9 Yes 9 No Infant transferred, status unknown BREASTFED AT DISCHARGE?	l s' l s'		9	None of the abov	78			
5 5 9 IF YES, NAME OF FACILITY INFANT TRANSFERRED DY Yes D No D Infant transferred, status unknown BREASTFED AT DISCHARGE?	her her	56. WAS INFANT TRANSFERRED WI	THIN 24 HOURS O	F DELIVERY?	Yes 9 No 157. IS INFANT LIVIN		REPORT? 15	. IS THE INFANT BEING
	Not No.	IF YES, NAME OF FACILITY INFA	NT TRANSFERRED	)				

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CHILD 1. CHILD'S NAME - (FRIST, MODULE, LAST	SUFF&]		2a. DATE OF BIRTH - MONTH, D	иу, уеляј / <mark>26. тибо</mark> г викл	
WIENT HAIK A 3.SEX / 44.PLUR E 25日 新福祉(1994) 王治王 新福祉(1994) 王治王 新福祉(1994)	ALITY - SINGLE, G (SPECIFY) 45. IF NOT SINGLE BIRT BORN FIRST, SECOND,	TH - Sa, PLAC	E OF BIRTH		
Female Sing	ETC. (SPECFY)	SC. FACILITY NAME - (IF NOT IN FACIL		IMBERI	
Brattleboro		Brattleboro Memoria	l Hospital		
A MOTHER'S NAME JRAST, MOOLE LA			7. DATE OF BIRTH - (MONTH, DA		
A. MOTHER'S BIRTH NAME , MAST MAKE		9. MOTHER'S BIRTH	ALCE - ISTATE OR FOREIGN COUN	- <u></u>	
102. RESIDENCE OF MOTHER - STREET			12 DATE OF BIRTH - (MONTH, D	10c. STATE	
13. FATHERS BIRTHPLACE - (STATE OR)	$\frac{1}{1-1} = \frac{1}{1-1} = \frac{1}$		-	······································	
		hame - 7		E CENTRED - PROMINE DAY, YEAR	<b>8</b>
Brittany Parent	WCENTIFIER	Hospital Ac	Iministrator Nov	ember 26, 2012	
Lois B. Trezise		CNM/CM			
	Cappen Tow	r Cles R	IMONTH.	ERECEIVED BY LOCAL REGISTRAR DAY, YEAR) Wenher 27,20	
rar	ette d. Capany	BRATTLEB	1	e-(month, day, year) DEC. 4 2012	
				original made	
	N	by Ca 73	ouri staff	dana Tanan ar	
FILE I	S A TRUE AND EXACT REPRODUCTION N THIS OFFICE.		ICIALLY REGISTERED A		
DATE	ISSUED: DEC: 2 4 2012.	ATTES	Harry UN	n vou	
	opy not valid unless prep <b>ared</b> on engraved l	/ border displaving state seal o	f Vermont.		
A Commencement					

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DH-PHS-BIR-2012	78453			RTMENT OF					
LOCAL FILE NUMBER		VEI					144	1600258 STATE FILE NUMBER	<b>X</b>
1. CHILOS NAME - (FRBT, M					€, 1, 1 	24 DATE OF BRITH	provita, dav, year)	26. TAKE OF B'RTH	
Male	AL PLURALITY SINGLE, TWIN ETC. (SPECIFY) Single		46. IF NOT SINGLE BIR BORN FIRST, SECOND ETC. (SPECFY)		SL PLACE Hosp	eof Brith Dital			
Sh. CITY OR TOWN OF BRI Middlebury			,	1		TY, GNE STREET ADORS	SS AND INVBER)		1
PARENTS	AND					7. DATE OF SINTH - (	ίοιπή άνγ, yearj		题
LAST HAVE AT BIRTH				· · · · · · ·	BIRTHPLACE - (ST	ATE OR FOREIGN COUNT	N 1999 1994 		
10a. RESIDENCE - STREET	AND IN BABER				Db. CITY OR TOWN		10x STATE		
11. NAVE-(FRST, MOOLE, I		ante da RAN ESSE	1940 <b>(</b>			12. DATE OF BIRTH-			
11 BIRTHPLACE - (STATE O									
				(		<b></b>			Hite
14a CERTIFIERS NULLE Denise Roycew					the mut	lministrator	14. DATE CERTIFIED June 28, 201		500) 1
Heather Brow	<b>2.5</b> - 1014 - 1017 - 1007 - 1				S. MIE CNM/CM				
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5 M A A							ON THE ORIGIN	······································	цёў.) G 1

STRUCKING ON CONTRACTOR
VERMONT DEPARTMENT OF HEALTH CERTIFICATE OF LIVE BIRTH FOR A FOREIGN BORN CHILD CHILD LCHLUS NAME (FRET, MODILE LAST, SWFFM)
4. COUNTRY OF BIRTH 4. COUNTRY OF BIRTH China PARENTS 5. NAME - (PRST, MOOLE LAST, SWFFR) 1. DATE OF BIRTH - (MONTR), DAY, YEAR) 1. DATE OF BIRTH - (MONTR), DAY, YEAR)
A BIRTHPLACE - (STATE OF POREGIN COUNTINY)      A BIRTHPLACE - (STATE OF POREGIN COUNTINY)      B. BIRTHPLACE - (STATE OF POREGN COUNTINY)      B. BIRTHPLAC
12. BIRTHPLACE - (STATE OR FOREIGH COUNTRY) 13. SOURCE OF INFORMATION ABOVE Decree issued October 13, 2016 by Orleans District Probate Court, Judge John P. Monette presiding: Decree issued October 13, 2016 by Orleans District Probate Court, Judge John P. Monette presiding: THIS CERTIFICATE IS NOT EVIDENCE OF UNITED STATES CITIZENSHIP ADDRESSING CERTIFICATE IS NOT EVIDENCE OF UNITED STATES CITIZENSHIP
CHARMING ATTERNSTREE PLANSING TO TITLE 18 CHARMEN AND TO TITLE 18 CHARMENANT AND TO TITLE 18 CHARMEN AND TO TITLE 18 CHARMEN AND TO T
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 CUSTOPIAL AGENCY. JAN 2 3 2017 DATE ISSUED: This copy not velid unless prepared on engraved border displaying state seal of Vermont.

VDH-PHS-BTP-2011

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### VERMONT DEPARTMENT OF HEALTH BURIAL-TRANSIT PERMIT

Permit No.

	Permit for Removal	, Disinterment and	Reinterment	
I. Decedent's Nâme	· · · ·		2. Sex	3. Date of Death
· . c				
. City/Town of Death	5. Date of B	inth 6,4P	lace of Birth	
•			As an and	
Name and Address of Funeral	Director			
n an			±	
ERMISSION REQUESTED FOR	· /Check only one boy	and complete the an	propriate section)	
Temporary Storage or Donation		Cremation (Section C		Entombment (Section D)
Removal From Temporary Stor				From State (Section E)
ECTION A: IF TEMPORARY ST				
lame of Cemetery/Place or Dona		City/Tov	un	Date
rame of Centercry/Place of Doing	aoist dointy		**1	Date
ERMISSION GIVEN TO DISPO				I) Date
Signature of Clerk/Deputy or Fund	srai Director	City/Tov	VN	Date
		<u> </u>		<u> </u>
Signature of Sexton/Cemetery Of	licial or Representative	e of Organization R	eceiving Donation	Date
· · · · · · · · · · · · · · · · · · ·			<u></u>	Sec. 19
SECTION B: IF REMOVAL FROM	TEMPORARY STOR	AGE/PLACE OF D	ONATION OR DISIN1	ERMENT
Name of Cemetery/Place or Facil	ily from which body is	being removed City	/Town	Date
PERMISSION GIVEN TO DISPO	SE OF SAID BODY A	S STATED ABOVE	(Title 18, V.S.A. 520	
Signature of Clerk/Deputy or Fun		City/Tov	Contraction of the local data and the local data an	Date
Signature of Sexton/Cemetery Of	ficial			Date
signature of ocxions beindlery of	noizi		· · · · · · · · · · · · · · · · · · ·	
SECTION OF IS CREMATION IN	(EDMO)/T			a the second
SECTION C: IF CREMATION IN N Name of Crematorium	/ERMONT	Chuffe		Date
	Terretana Terre	City/Tov		
Mount Anthony Cremation S		Bennin		June 20, 2016
PERMISSION GIVEN TO DISPO				
Signature of Clerk/Deputy or Fun	eral Difector	City/Tov	<b>vn</b>	Date
Runt	<u>1-111.78</u>	BER	ININGTON	June 20,20.
Signature of Crematorium Official	nt		er Number	Date
Sam the	hut		0243	June 30,20
SECTION D: IF BURIAL OR ENT	OMBMENT IN VERMO	DNT	49	
Name of Cemetery		City/Tov		Date
				н. - При станция и стан
PERMISSION GIVEN TO DISPO			(Title 18 VSA 520	<u> </u>
Signature of Clerk/Deputy or Fun		City/Tov		Date
and a second of the			•••	
Body was: 🔲 Buried 🛛	Entombed	Date	·	
Section Lot Number	er Grave Nu	Imber Signatu	re of Sexton/Cemeter	y Official
SECTION E: IF REMOVAL FROM	STATE		میں۔ میں دیکی م	ل <u>ېږې د د مانځې چې الله د د</u>
Name of Cemetery or Place to wi		n CibuTown Stat	or Country	Date
where or callengery of Poster 10 Mil	INTERATION IS DEIDTI TAKE	IN TORALIOMIE OLGIE	a or Country	Date
	ioro body io being take			1
- -				
PERMISSION GIVEN TO DISPO	SE OF SAID BODY A	S STATED ABOVE	(Title 18, V.S.A. 520	
PERMISSION GIVEN TO DISPO Signature of Clerk/Deputy or Fun	SE OF SAID BODY A		(Title 18, V.S.A. 520	1) 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)

FETUS		SITION PERMIT FO		5. [64 B/1]	ы. н. ,
FETUS-NAME FIHST(If given)	MIDDLE (I given) LAS		DATE OF DELIVERY	(Month, day, year)	HOU
1.			28.		2b.
CITY, TOWN OF DELIVERY	24.	SPITAL -NAME (If not in	rospital, give street and	number)	
SEX: THIS DELL			SIRTH WEIGH	WHEN DID FETU	IS DIE?
	רואד מאשד ⊒		•		LABOR
					LABORI Elivery
UNKNOWN [ 3. 4.	J	۲ <u>۵</u>			
3. 4.			5.	. 6.	
PARENTS		A general the states			
7a. MOTHER'S NAME (First, Middle, Las			8. DATE OF BIRTH (M	onth, Day, Year)	
			•		
9a: RESIDENCE-STATE 95	CITY OR TOWN		10. BIRTHPLACE (Sta	te or Foreign Countryj	
					•
11. MOTHER'S MAILING ADDRESS (SI	reet and Number or Rural Route I	Number, City or Town, S	tate, Zip Code)	· · · · · · · · · · · · · · · · · · ·	
	, 				
12. FATHER'S NAME (First, Middle, Las	() 13. DATE OF I	BIRTH (Morth, Day, Yea	r) 14. BIR	THPLACE (State or Fore	ign Cour
This permit	OR DISPOSITION: , when completed	and bearing	the name of	a certi-	
This permit- fying physi-		s authority f	or final dis	nosition	
This permit fying physiof the feta V. S. A.)	, when completed cian, constitutes	s authority f Tied abov <b>e.</b>	`or final dis (Title 18, 5	nosition	
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## 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

 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 Vernont 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\_\_\_

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

and in container number

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 scattered, buried etc. m Towr cemetery or other location signed State 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

	1. DECEDENT'S LEGAL NAME (Inclu	ude AKA's l	lf anv) (First. Mid	idle, Last)		2. SEX	3. SOCIAL SECU	RITY NUMBER		
1 1	,			,,						
	4a. AGE-Last Birthday 4b. UNDER 1 (Years)	1 YEAR	4c. UNDER 1	DAY 5.	DATE OF BIRTH (M	o/Day/Yr) 6. BIRTH	PLACE (City and S	tate or Foreign C	Country)	
	Months	Days	Hours Mir	nutes						
	7a. RESIDENCE-STATE		7b. COUNTY	L		7. CITY OR TOW	/N			
			<u> </u>							
	7d. STREET AND NUMBER			7e. APT. N				g. INSIDE CITY		
1			AL STATUS AT			10. SURVIVING S	POUSE'S NAME	lf wife, give nam	e prior to first n	narriage)
ı l			d 🗆 Never Mari							
ä	11. FATHER'S NAME (First, Middle, L	.ast)				12. MOTHER'S	NAME PRIOR TO	FIRST MARRIA	GE (First, Midd	lle, Last)
8										
E L	13a. INFORMANT'S NAME	13b, RE	ELATIONSHIP T	O DECEDE	.NT	13c. MAILING	ADDRESS (Street a	and Number, City	, State, Zip Co	de)
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2										
To Be Completed/ Verified By: FUNERAL DIRECTOR:	IF DEATH OCCURRED IN A HOSPIT	TAL:	14. PLACE		I (Check only one: see DEATH OCCURRED		ER THAN A HOSP	PITAL:		
5 E	D Inpatient D Emergency Room/Outp			DH	lospice facility 🗆 Nursi	ing home/Long term				
통한	15. FACILITY NAME (If not institution,	Aine anger	a number)	10. CI	Y OR TOWN , STATE	, AND ZIF CODE			17. 0001	NTY OF DEATH
	18. METHOD OF DISPOSITION:	Burial D (	Cremation		E OF DISPOSITION (	Name of cemetery	crematory other of	ace)		
	Donation D Entombment D Rer			10. 10.0		interne er eeneterj,	erennamiy, oarer p			
	Other (Specify):     LOCATION-CITY, TOWN, AND ST	TATE	2	1. NAME A	ND COMPLETE ADD	RESS OF FUNERA	L FACILITY			
	22. SIGNATURE OF FUNERAL SERV	ICE LICEN	ISEE OR OTHE	RAGENT				2	3. LICENSE	NUMBER (Of License
<u> </u>										
	ITEMS 24-28 MUST BE CON WHO PRONOUNCES OR CE			ON	24. DATE PRONOL	JNCED DEAD (Mo/I	Day/Yr)		25. 1	TIME PRONOUNCED
1 1	26. SIGNATURE OF PERSON PRONO			hen applical	ble)	27. LICENSE NUM	IBER		28. DATE SI	IGNED (Mo/Day/Yr)
ſ										
	29. ACTUAL OR PRESUMED DATE C (Mo/Day/Yr) (Spell Month)	OF DEATH		30. AC	CTUAL OR PRESUME	D TIME OF DEATH	ł	31. WAS MED		
	(wordshift) (abeli Monut)							CORONEI	R CONTACTE	D? 🗆 Yes 🗆 No
	32. PART I. Enter the chain of event	CAUS ts-disease	SE OF DEAT	'H (See in molications-	nstructions and that directly caused the	i examples)	enter terminal even	ts such as cardia	10	Approximate interval:
	arrest, respiratory arrest, or ventr lines if necessary.	ricular fibrili	lation without she	owing the eti	iology. DO NOT ABBI	REVIATE. Enter on	ly one cause on a l	ine. Add addition	nal	Onset to deat
	-									
	IMMEDIATE CAUSE (Final disease or condition> a									
	resulting in death)		1	Due to (or a	s a consequence of):					
	Sequentially list conditions, b if any, leading to the cause			Due to (or a	s a consequence of):					
	listed on line a. Enter the UNDERLYING CAUSE c				,,					
	(disease or injury that			Due to (or a	as a consequence of):			_		-
	initiated the events resulting in death) LAST d									
. 7	PART II. Enter other significant condition	ons contrib	uting to death bu	ut not resulti	ng in the underlying cr	ause given in PART	1	33. WAS AN	N AUTOPSY P	ERFORMED?
								24 14/606 /		lo DINGS AVAILABLE T
								COMPLETE		OF DEATH? D Yes
	35. DID TOBACCO USE CONTRIBUT TO DEATH?		IF FEMALE: D Not pregnant v	within past v	ear		37. MANNER OF	DEATH		
To Be Completed By: MEDICAL CERTIFIER	D. Yes D. Deshable						🗆 Natural 🖂	Hamicide		
불법	Yes Probably		Pregnant at tin				a Accident a	Pending Investig	gation	
SA	🗆 No 🗀 Unknown	C	Not pregnant,	but pregnan	it within 42 days of dea	ath	a Suicide a	I Could not be de	termined	
		C	🗆 Not pregnant, I	but pregnan	it 43 days to 1 year be	fore death				
		,	🗆 Unknown if pr	regnant with	in the past year					
			IRY 40	PLACE OF	INJURY (e.g., Deced	ent's home; constru	ction site; restaura	nt; wooded area)	41	<ol> <li>INJURY AT WORK</li> </ol>
		IE OF INJU	10.							
	38. DATE OF INJURY 39. TIM (Mo/Day/Yr) (Spell Month)	IE OF INJU		_	_					🗆 Yes 🗆 No
		IE OF INJU		C	City or Town:					
	(Mo/Day/Yr) (Spell Manth) 42. LOCATION OF INJURY: State: Street & Number:	ie of inju			Sity or Town:	Apartment	No.:	Zip C		🗆 Yes 🗆 Na
	(Mo/Day/Yr) (Spell Month) 42. LOCATION OF INJURY: State:	ie of inju	· · · ·	C	City or Town:	Apertment	No.:		NSPORTATIC	
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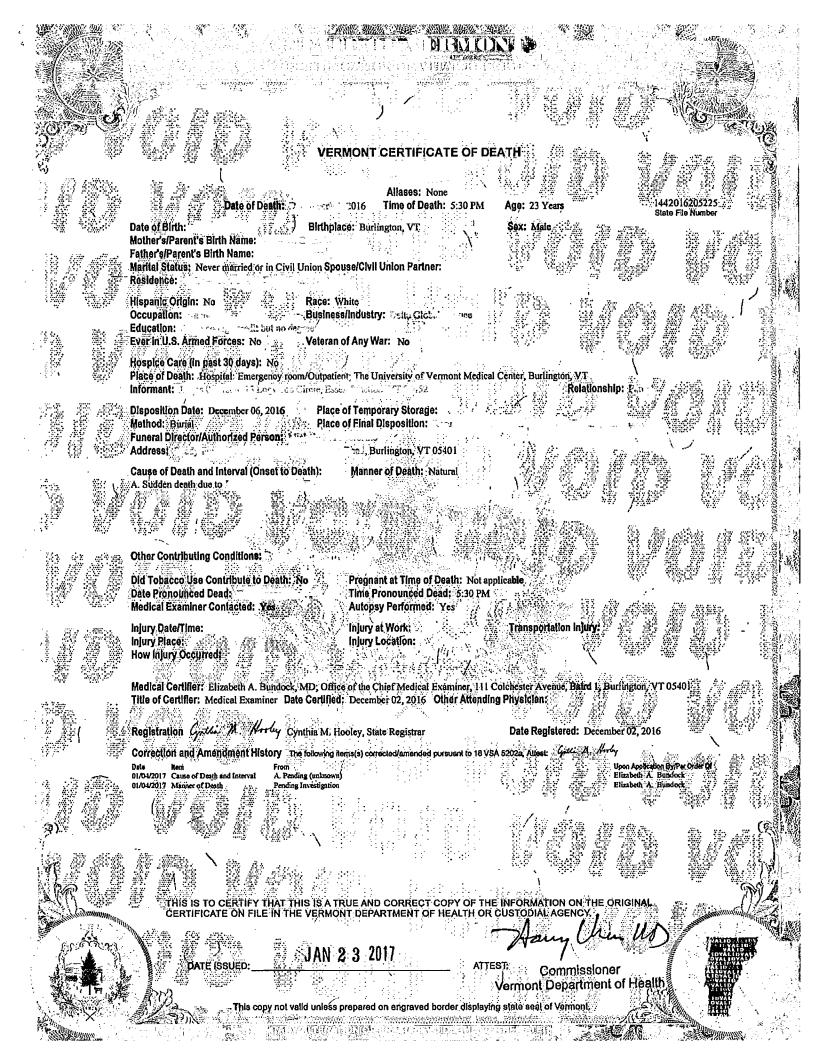
11111 1120 112 7418 DEPARTMENT OF HEALTH DH-PHS-DTH-89C S.F. EITSILWE Frat Hole Lan TYPE OR PRINT IN BLACK INK ģi: . 19 • - - - - a ; SOCIAL SECURITY NAME LAGE (MA SOLUNDER I YEAR SC. UNDER I DAY Menta QŢŔĔĬ N.cainy H E Fonteri - El ca T pd Ũ 15 KADO DECEDENT'S EDUCATION . ว่างม . 1 22. FATHER & NAVE FOR ALALAS I D. WITTERS HAVE Tras. Midde Mader Surveye WMEDIATE CAUSE (Final d. or condition reasting in death] ally Fist conditions, W ing to immediate riter UNDERLYING OUE TO FOR AS A CONSEQUENCE OF OUE TO OT AS A CO SECT, ENCE OF sonicanto oll lugar A 00% Oses CI Action OUR OF DEAT (No., Day, 11. O THÉ BÉ BÍ OC JÉH NOM È DOL, ON THE BASH OF THE CASE H'STORY, EXAMILATON AND O NESTIDATION DE ATA OCCURACIÓ AT THE TIVE, DATE AND PLACE AND THE TO CAUSE(S) AND Osalpy. 1.3 DParcking Uver Einte CED DEAD ON  $Cm_i q$ torigino (HOMY? `১০ MCGOX. [] Timp 411 WETHOD OF DISPOSITION Adirondack-Burlington QC n □oivis So. Burlington, Vt ATURE OF FUNDING ORECTOR OF AUT Ready Funer Inc., 261 Shelburne Rd 11/16/2001 Burlington 05401 A DATE RECENTION OCH R November ΰ16, 2001 11.1 DATE (Month Oar, Year) . ; ; **;** ; Clerk/Treasurer's office Burlington, Vt. A TRUE COPY ATTEST 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

> This copy not valid unless prepared on engraved border displaying state seal of Vermont. den normalise and a second second

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Date of Death:

DH-PHS-PROD-2012

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

1	1a. DECEDENT'S LEGAL NAM	ME (First, Middle, Last, Suffix)		Туре	or Print in Bla	ack Ink						
	1b. ALIASES (Any other name	es the decedent used or was kn	own as)			1c. E	ECEDE	NT'S LAS	T NAME AT E	BIRTH		
	2. SEX: Male Female 5. DATE OF BIRTH (Month, Da	3. SOCIAL SECURITY NUMB		GE-LAST ears)	BIRTHDAY		Months		NDER 1 YEA Days ity and State of		Hours	IF UNDER 1 DAY Minutes Province if Canada)
	7a. RESIDENCE STREET AND		•					TOWN O	FRESIDENC	E 7c. STA	ATE OR FORE	IGN COUNTRY
SUCH	8a. EVER IN U.S. ARMED FOF	OF DEATH: Married	No Married, but se Union dissolutior	parated	SO, WHAT			SURVIVIN	IG SPOUSE /	CIVIL UNION	PARTNER	10b. SEX OF SURVIVING SPOUSE/PARTNER
AS	11. FATHER'S OR PARENT'S 13a. INFORMANT'S NAME (Fi		ast)						ENT'S BIRTH	NAME ( <i>First</i>	t, Middle, Last)	
OR PERSON ACTING	13c. INFORMANT'S MAILING ( 14. DECEDENT'S EDUCATION level of school completed a	N LEVEL: (Check the box that i			•	15						t best describes whether box if decedent is not
AL UINECTON ON P	<ul> <li>8<sup>th</sup> grade or less</li> <li>9<sup>th</sup> - 12<sup>th</sup> grade; no diple</li> <li>High school graduate or GED completed</li> <li>Some college credit, but no degree</li> </ul>	<ul> <li>Associate degre</li> <li>Bachelor's degre</li> <li>Master's degree</li> <li>(e.g., MA, MS, M</li> <li>Doctorate (e.g.,</li> </ul>	ee (e.g., BA, AB, Eng, MEd, MSW	, MBA)	, LLB, JD)		Spanis D No D Ye D Ye D Ye	sh/Hispan o, not Span us, Mexica us, Puerto us, Cuban	ic/Latino.) hish/Hispanic/ n, Mexican Ar	Latino/Latina nerican, Chica	ano/Chicana	box // decedent is not
Completed/verified By: FUNEHAL DIHECION	16. DECEDENT'S RACE: (C White Black or African America American Indian or Alas (Name of the enrolled or	án 🗆 Chin ska Native 🗆 Filipi	n Indian ese		onsidered h Korean Vietnamese Other Asiar	ę,				n or Chamorro fic Islander (S		
pletea/ve	17. DECEDENT'S USUAL OCC of working life. DO NOT US	CUPATION (Indicate type of wo SE RETIRED)	ork done during n	nost	18. KIND (	OF BUS	INESS/			19. DID DEC (In past 3		IVE HOSPICE CARE?
IO RE COM		If death occurred in a hospital	Care Unit	[		Home /			n a hospital: Facility	Hospice Facil	lity 🗖 Dece	dent's Home
_	21a. FACILITY NAME (If not in		· · · · · · · · · · · · · · · · · · ·					D. CITY O	<u> </u>			21c. STATE
	22a. METHOD OF DISPOSITIO 22b. PLACE OF TEMPORARY	STORAGE (Name of cemeter	y, other place)		Donatio	on 🗖	Entomb					GE (City or Town, State)
	22d. PLACE OF FINAL DISPO				OF FUNE	RAL FA	CILITY					(City or Town, State) City, State, Zip Code)
:	24. SIGNATURE OF FUNERAL	L SERVICE LICENSEE OR AL	THORIZED PEF	SON		25. VE	RMONT	LICENS	ENUMBER	26. DATE (	OF DISPOSITIO	ON (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.

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

			Type or Print in	Black Ink					
19. DID DECEDENT RECEIVE HO	SPICE CARE? (In p	ast 30 days) 🗖 Yes							
20. PLACE OF DEATH If d	eath occurred in a ho	ospital:	If death occu	rred somev	where other ti	han a hosp	ital:		
(Indicate only one) 🛛 I	npatient 🔲 Ini	tensive Care Unit		g Horne / L	ong Term Ca	re Facility	🛛 Hospice	Facility 🗂 Dec	edent's Home
Emergenc	y Room/Outpatient	Dead on Arrival	Other	(specify)					
21a. FACILITY NAME (If not institut	tion, give street and i	number)			21b. CITY O	R TOWN			21c. STATE
				[					
27. MANNER OF DEATH:	Note: All a	leaths that are not "Nat	ural" should be refe	erred to a M	Aedical Exam	iner. Call 1	-888-552-295	2.	
□ Nat						ng Investig		Could Not Be [	
		diseases, injuries, o							events such as
		rrest, or ventricular i ine. Add additional l			g the ellolog	<i>уу. DO</i> N		VIA I E.	
-								APP	ROXIMATE INTERVAL: ONSET TO DEATH
IMMEDIATE CAUSE (Final								1	
disease or condition resulting in death.)	► a	Due to (or as a co						-	
iesulang in deam.j			nisequence or).						
Sequentially list conditions,	b	Due to (or as a co						_	· · · · · · · · · · · · · · · · · · ·
if any, leading to the cause listed on line a. Enter the		Due to (or as a co	onsequence of):						
UNDERLYING CAUSE									
(disease or injury that initiated the events resulting	с.	· • .							
in death) LAST.		Due to (or as a c	onsequence of):						
-)									
	d								
29. CAUSE PART II. Enter other	significant conditi	ions contributing to	death but not res	sulting in	the underly	ing cause	given in PA	ART I.	
30. DID TOBACCO USE CONTRIB	UTE TO DEATH?		Not pregnant w				Not pregnant	, but pregnant 43 c	lays to 1 year before death
Yes Probably			Pregnant at tim					regnant within the	past year
32a. WAS MEDICAL EXAMINER	005 HE	CASE NUMBER	Not pregnant, t		sy PERFOR	•			TOPSY AVAILABLE TO
CONTACTED?	360. M.E	. GAUE NUMBER		_				LETE CAUSE OF I	
🗆 Yes 🗖 No			. ⊔	Yes 🗆	I NO	,		Yes 🖸 No	
E AND DE ANT	orned a com	CEOFOCATH (PLAC	De STREDENH	SHOWED	<u>estim</u>	ED BY A N	EDICAL EXA	MINER. CALL 1-	388 <b>(1997)</b>
35. DATE OF INJURY	36. TIME OF INJL		37. PLACE OF I	NJURY (a.					38. INJURY AT
(Month, Dáy, Year)	Į		wooded area	3)					
39. LOCATION OF INJURY (Street	and Number, City of	r Town, State)	+ **						· · · · · · · · · · · · · · · · · · ·
							<u> </u>	· · · · ·	ا ·····
40. DESCRIBE HOW INJURY OCC	URRED					_		TION INJURY, SPI	
							Driver/Operate	or 🛛 Pedestria	n
							Passenger	D Other (sp	ecify)
42a. ACTUAL OR PRESUMED DA	TE OF DEATH	42b. ACTUAL OR PRE	SUMED TIME OF	DEATH	42c. DATE	PRONOUI	NCED DEAD	42d. TIME PF	ONOUNCED DEAD
(Month, Day, Year)				ПРМ		h, Day, Yea		1	
43a. SIGNATURE OF CERTIFIER occurred at the time, date, and				xamination	, and/or inves	stigation, d	eath 4	3b. DATE CERTIF	ED (Month, Day, Year)
				1					
	ar Print								
43c. NAME OF CERTIFIER (Type of	n mung							43d. LICENSE	NUMBER
								ACT PHONE NU	
	treat and Number C	ity or Town State 7:-	Codel						
438. ADDRESS OF CERTIFIER (S	treet and Number, C	ity or Town, State, Zip	Code)				44. CON	)	NDE <del>N</del>
·				46. NAMI	E OF ATTEN	DING PHY	(	)	IFIER (Type or Print)
45. TITLE OF CERTIFIER: Phys	sician 🔲 Pati		dical Examiner	46. NAMI	E OF ATTEN	DING PHY	(	)	

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 #4	5-2-16 Frdm		Dept. of Health L State File#	Jse ONLY	
APPLICANTA Ia. Name (First, Middle,			(Check One) ame at Birth	Ic. Sex	
	LASU)			Female Male	
2a. State of Residence	2b. City or Town of	Residence	3. Date of Birth (month, day, year)		
1 1			<u> </u>		

APPLICANT B	HUSBAND		SPOUSE	(Check one)	
4a, Name (First, Middle, La	ıst)		4b, Last Nam	e at Birth	4c. Sex
5a. State of Residence	5b. C	ity or Town of Residence		6. Date of Birth (m	onth, day, year)
· · · · · · · · · · · · · · · · · · ·				<u> </u>	

MARRIAGE	
7a. State of foreign country of this marriage Vermont	7b. City or Town of this marriage 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)

DECREE		
10. I certify that this decree became absolute (final) on (month, day, year) 11 / 22 / 2016	11. Type of decree (check one)       Image: Divorce       Image: Annulment	12, County of decree FRANKLIN
13. Legal grounds for decree (specify) Parties have lived separate in excess of 6 consecutive months	14. Court Minager's Name	15. Date signed (month, day, year) <u>12-1 14 116</u>

9/09 SML

VDH-VR-DIV-9/2009

DEPARTMENT OF HEALTH VERMONT RECORD OF DIVORCE OR ANNULMENT	
Dept. of Health Use ONLY Docket #  The second	
Ia. Name (First, Middle, Last)       Ib. Last Name at Birth       Ic. Sex         Lemale	
APPLICANT B APPLICANT B AND KI WIFE SPOUSE As Name (First, Middle, Last) Ac. Sex Ac. Sex	
Sa. State of Residence     Sb, City or Town of Residence     6. Date of Birth (month, day; year)       It ic	and a state of the
MARRIAGE       7b, City or Town of this marriage       7c. Date of this marriage (month, day, year)         7a. State or foreign country of this marriage       7b, City or Town of this marriage       7c. Date of this marriage         8a. Date couple hast resided in same household       8b. Number of children under 18 in this household as of the date in item Ba.       8b. Number of children under 18 in this household as of the date in item Ba.	and a second
None     9a: Name of Petitioner's Attorney     9b. Attorney's Address (street, city/town, state, zip)	ant management
DECREE	L . ACCORDING -
10.1 certify that this decree became absolute (Inal) on (month, day, year)11. Type of decree (check one) $M$ Divorce12. County of decree $W$ (MdSO)0510320/6Image: AnnulmentWindSO)13. Legal grounds for decree (specify) $GT$ mos Separation14. Court Manage's Name Andrew Store15. Date signed (month, day, year) $OS 106 12016$	termination of the second second
9/0 <sup>9</sup> SML	a survey of the second s
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 CUSTOPIAL AGENCY Many Man M JAN 2 3 2017 ATTEST: Commissioner	
DATE (SSUED: Vermont Department of Health This copy not valid unless prepared on engraved border displaying state seal of Vermont TTANYANGERENTION FOR TABLE	ALL AND

## VERMONT DEPARTMENT OF HEALTH APPLICATION FOR VERMONT LICENSE OF CIVIL MARRIAGE FEE FOR CIVIL MARRIAGE LICENSE \$45.00

	idle, Last)	IDE			OUSE	(check one)	RTH (Maiden Suman	ne)
2. SEX	3. DATE OF BIRT	H (Month, Day	, Year)	4. BIF		(State or Foreign Country)		
5a. RESIDENCE ADDRESS	I (Number and Street	l)		l		5b. CITY OR TOWN OF	RESIDENCE	1999 (MILLING) -
5c. STATE OF RESIDENCE						5d. COUNTRY OF RESI	DENCE	
6a. FATHER'S OR PARENT	'S NAME (First, Mid	Idle. Last Nam	e at Birth)		6b.	BIRTHPLACE (State or Fi	preian Country)	
			,			,	•	
7a. MOTHER'S OR PAREN	<b>I'S NAME</b> (First, Mid	ddle, Last Nam	e at Birth)		7b. I	BIRTHPLACE (State or Fo	preign Country)	
APPLICANT B	BR	IDE	GROOM	SP	OUSE	(check one)		
8a. LEGAL NAME (First, Mic	Idle, Last)					86. LAST NAME AT BI	RTH (Malden Suman	ne)
9. SEX	10. DATE OF BIR	TH (Month, Da	iy, Year)	11. 8	IRTHPLACE	(State or Foreign Country	()	
12a. RESIDENCE ADDRES	S (Number and Stree	et)				12b. CITY OR TOWN OF	RESIDENCE	
12c. STATE OF RESIDENC	Ę					12d. COUNTRY OF RES	IDENCE	
13a. FATHER'S OR PAREN	T'S NAME (First, Mi	iddle, Last Nar	ne at Birth)		13b.	BIRTHPLACE (State or I	Foreign Country)	
14a. MOTHER'S OR PAREN	IT'S NAME (First, M	liddle, Last Na	me at Birth)		14b.	BIRTHPLACE (State or I	Foreign Country)	
14a. MOTHER'S OR PAREN	IT'S NAME (First, M	liddle, Last Na	me at Birth)		14b.	BIRTHPLACE (State or I	Foreign Country)	
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THE CONFIDEN	ITIAL INFORM	ATION BE	LOW MUST BE C		TED. IT W	ILL NOT APPEAR	ON CERTIFIED	D COPIES OF THE RECO Marria <b>ge or civil u</b> nion e
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Date	license	issued	_

Clerk issuing license \_

### DH-PHS-MARLIC-2012

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APPLICANT		GROOM	SPOUSE (che		NAGE STATE FILE NUM		
14. LEGAL NAME (Fin				15. LAST SAT BIRTH			
• Jats Mari							
2. SEX	J. DATE OF BIRTH (Month, Day, Yea	r)	4. BIRTHPLACE (SI	tals or Foreign Country)	·····		
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5a. RESIDENCE ADDR	ESS (Number and Street)			5b. CITY OR TOWN OF RES	IDENCE		
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Sc. STATE OF RESIDE	NCE			EL COUNTRY OF RESIDEN	KE		
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54. FATHER'S OR PAR	ENT'S NAME (First, Middle, Last Name at Bi	rth)		6b. BIRTHPLACE (State or Fore	ign Country)		
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	RENTS NAME (First, Mkkle, Last Name at B	irth)	· · · · · · · · · · · · · · · · · · ·	7b, BIRTHPLACE (State or Fore	ign Country)		
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	e. e. 132						
		correct to the best of	of our/my knowledge	and belief and that we are f	ree to marry under the laws of Vermont		
15a. SIGNATURE (Ap)	Micgrit AL	156. DATE SIGNED		TURE (Applicant B)	16b. DATE BIGNED		
				en e			
CERTIFICATIO	I hereby certify uset the above samed pa tor the facts stated in the foregoing declaration of	HISONS have made	OFFICIANT	(See instructions on back)			
c bne egainem	omplied with the marriage laws of the State of Ve	armont.	authorized to pe	erform a mantaça.	NLY of the above named parties by any person duly		
17 DATE ON WHICH I		58t)	18a. I CERTIFY THAT T. MARRIED ON (Month,	HE ABOVE PERSONS WERE Day, Year)	18b. WHERE MARRIED - CITY OR TOWN		
March 3, 201	- Ar		<u> </u>		in the second		
17h TOWN CLERK	MALLOVAL	Arch	18c. AUQNATURE OF P	ERSON PERFORMING CEREMONY	18d, TITLE		
Fundan ( Man ASUN , ISST				المريدية المستحد المستحد المستحد			
The TOWN OR CITY					18. TELEPHONE NUMBER		
Town of Bennington							
17d. THIS LICENSE IS 1	VALID FROM March 3, 20	<u>016 то</u>	11g. MAILING ADDRES	S OF PERSON PERFORMING CERI	EMONY (Number and Birsel, City or Town, State,2		
N.4.5	2, 2016 DATE			-	•		
May 2		متدام للتراب الترا			· · · · · · · · · · · · · · · · · · ·		
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REGISTRATIO		- 1 - <u></u>					
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