2124
REGISTER NUMBER 69

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER

RESIDENCE

1. NAME: FIRST Jean | MIDDLE Paul | LAST Deshaies
2. SEX: MALE [X] 1 FEMALE [ ] 2
3A. DATE OF DEATH: MONTH 07 DAY 26 YEAR 2015
3B. HOUR: 10:45 P m

NCHS

4A. PLACE OF DEATH (Check one): HOSPITAL DOA ER [ ] [ ] | HOSPITAL OUTPATIENT [ ] | HOSPITAL INPATIENT [ ] | NURSING HOME [X] | PRIVATE RESIDENCE [ ] | HOSPICE FACILITY [ ] | OTHER (Specify): [ ]
4B. IF FACILITY, DATE ADMITTED: MONTH 07 DAY 24 YEAR 2015

4C

4C. NAME OF FACILITY: (If not facility, give address) Valley Health Services
4D. LOCALITY: (Check one and specify) CITY [ ] VILLAGE [X] TOWN [ ] Herkimer
4E. COUNTY OF DEATH:

4G

4F. MEDICAL RECORD NO. 445978
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO [X] YES [ ]

DECEDENT

5. DATE OF BIRTH: MONTH 04 DAY 14 YEAR 1926
6A. AGE IN YEARS: 89 yrs.
6B. IF UNDER 1 YEAR ENTER: months days
6C. IF UNDER 1 DAY ENTER: hours minutes
7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Ilion, NY
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

7A

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO [X] 0 YES [ ] 1
9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. A [X] No, not Spanish/Hispanic/Latino B [ ] Yes, Mexican, Mexican American, Chicano C [ ] Yes, Puerto Rican D [ ] Yes, Cuban E [ ] Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be: A [X] White/Caucasian B [ ] Black or African American C [ ] Asian Indian D [ ] Chinese E [ ] Filipino F [ ] Japanese G [ ] Korean H [ ] Vietnamese J [ ] Native Hawaiian K [ ] Guamanian or Chamorro M [ ] Samoan N [ ] American Indian or Alaska Native (specify) P [ ] Other Asian (specify) R [ ] Other Pacific Islander (specify) S [ ] Other (specify)

7B

11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. 1 [ ] ≤ 8th grade 2 [ ] 9th-12th grade; no diploma 3 [X] High school graduate or GED 4 [ ] Some college credit, but no degree 5 [ ] Associate's degree 6 [ ] Bachelor's degree 7 [ ] Master's degree 8 [ ] Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER: 124-22-9073
13. MARITAL STATUS: NEVER MARRIED [ ] 1 MARRIED [ ] 2 WIDOWED [X] 3 DIVORCED [ ] 4 SEPARATED [ ] 5
14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.

15A. USUAL OCCUPATION: (Do not enter retired) Carpenter
15B. KIND OF BUSINESS OR INDUSTRY: Manufacturing
15C. NAME AND LOCALITY OF COMPANY OR FIRM: Remington Arms Co. Ilion, New York

SI

16A. RESIDENCE: (State or Country if not USA) New York
16B. County or Region/Province if not USA: Herkimer
16C. LOCALITY: (Check one and specify) CITY [ ] VILLAGE [X] TOWN [ ] Herkimer
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? [X] YES [ ] NO IF NO, SPECIFY TOWN:

25

16D. STREET AND NUMBER OF RESIDENCE: 150 West German Street
16E. ZIP CODE: 13350

PARENTS

17. BIRTH NAME OF FATHER / PARENT: FIRST Paul | MI | LAST Deshaies
18. BIRTH NAME OF MOTHER / PARENT: FIRST Edouardiana | MI | LAST Tourigny

30

19A. NAME OF INFORMANT: Sharon Candella
19B. MAILING ADDRESS: (include zip code) 14 Huyck Avenue Middleville, NY 13406

31

DISPOSITION

20A. [X] BURIAL 2 [ ] CREMATION 3 [ ] REMOVAL 4 [ ] HOLD 5 [ ] DONATION 6 [ ] ENTOMBMENT — MONTH 08 DAY 01 YEAR 2015
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Oak Hill Cemetery
20C. LOCATION: (City or town and state) Herkimer, NY

31B

21A. NAME AND ADDRESS OF FUNERAL HOME: Enea Family Funeral Home 220 North Washington Street Herkimer, NY 13350
21B. REGISTRATION NUMBER: 00530

QR

22A. NAME OF FUNERAL DIRECTOR: Kevin E. Enea
22B. SIGNATURE OF FUNERAL DIRECTOR: Kevin E. Enea
22C. REGISTRATION NUMBER: 11069

QS

23A. SIGNATURE OF REGISTRAR: Mary Jane Vredenburg
23B. DATE FILED: MONTH 07 DAY 29 YEAR 2015
24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Mary Jane Vredenburg
24B. DATE ISSUED: MONTH 07 DAY 29 YEAR 2015

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

QCOD

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: James S. Ward, MD | License No.: 110440-1 | Signature: | Month 07 Day 27 Year 2015
Certifier's Title: 0 [X] Attending Physician 0 [ ] Physician acting on behalf of Attending Physician 1 [ ] Coroner 2 [ ] Medical Examiner / Deputy Medical Examiner | Address: Burnett Hospital, 721 East Albany St. Herkimer, NY 13350
25B. If coroner is not a physician, enter Coroner's Physician's name & title: | License No.: | Signature: | Month Day Year
25C. If certifier is not attending physician, enter Attending Physician's name & title: | License No.: | Address:

CANCER

26A. Attending physician attended deceased: FROM Month 07 Day 24 Year 2015 TO Month 07 Day 26 Year 2015
26B. Deceased last seen alive by attending physician: Month 07 Day 24 Year 2015
26C. Pronounced Dead ON Month 07 Day 26 Year 2015 AT Time 10:45 P

27. MANNER OF DEATH: NATURAL CAUSE [X] 1 ACCIDENT [ ] 2 HOMICIDE [ ] 3 SUICIDE [ ] 4 UNDETERMINED CIRCUMSTANCES [ ] 5 PENDING INVESTIGATION [ ] 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 [ ] NO 1 [ ] YES
29A. AUTOPSY? NO [ ] 0 YES [ ] 1 REFUSED [ ] 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 [ ] NO 1 [ ] YES

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

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. IMMEDIATE CAUSE: (A) Respiratory Failure due to Aspiration Pneumonia — 72hrs
DUE TO OR AS A CONSEQUENCE OF: (B) Severe Dysphagia due to Cerebrovascular Accident — 5wks
DUE TO OR AS A CONSEQUENCE OF: (C) Hypertension, Congestive Heart Failure, Atrial Fibrillation — 10yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): Chronic Obstructive Pulmonary Disease
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 [ ] NO 1 [ ] YES 2 [ ] PROBABLY 3 [X] UNKNOWN

31A. IF INJURY, DATE: MONTH DAY YEAR | HOUR: m | 31B. INJURY LOCALITY: (City or town and county and state) | 31C. DESCRIBE HOW INJURY OCCURRED: | 31D. PLACE OF INJURY: | 31E. INJURY AT WORK? NO [ ] 0 YES [ ] 1
31F. IF TRANSPORTATION INJURY, SPECIFY: | 32. WAS DECEDENT HOSPITALIZED IN NO YES | 33A. IF FEMALE: 0 [ ] Not pregnant within last year 1 [ ] Pregnant at time of death 2 [ ] Not pregnant, but pregnant within 42 days of death | 33B. DATE OF DELIVERY: MONTH DAY YEAR

NAME OF DECEDENT: Jean Paul Deshaies DATE OF DEATH: 7/26/15 TIME OF DEATH: 10:45 AM PM