DOH-1961 (10/2005)

RECORDED DISTRICT 3154

REGISTER NUMBER 178

NEW YORK STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

RESIDENCE

NCHS

4C

4G

7A

7B

SI

25

30

31

31B

OR

OS

QCOD

CANCER

DECEDENT

1. NAME: FIRST Jeanne MIDDLE E. LAST Martinek
JEANNE MARTINEK

2. SEX: MALE ☐ 1 FEMALE ☒ 2

3A. DATE OF DEATH: MONTH 01 DAY 20 YEAR 2009

3B. HOUR: 11:07 Pm

4A. PLACE OF DEATH: (Check one) HOSPITAL DOA ☐ ER ☒ HOSPITAL OUTPATIENT ☐ HOSPITAL INPATIENT ☐ NURSING HOME ☐ PRIVATE RESIDENCE ☐ HOSPICE FACILITY ☐ OTHER (Specify): ☐

4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR

4C. NAME OF FACILITY: (If not facility, give address) Good Samaritan Hospital

4D. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☒ Islip

4E. COUNTY OF DEATH: Suffolk.

4F. MEDICAL RECORD NO. 0902002

4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☒ YES ☐

5. DATE OF BIRTH: MONTH 11 DAY 04 YEAR 1916

6A. AGE IN YEARS: 92 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) Bridgeport, CT

7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☒ 0 YES ☐ 1

9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.
A ☒ 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 ☒ 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)

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 ☐ 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: 057-16-8199

13. MARITAL STATUS: NEVER MARRIED ☐ 1 MARRIED ☐ 2 WIDOWED ☒ 3 DIVORCED ☐ 4 SEPARATED ☐ 5

14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name.

15A. USUAL OCCUPATION: (Do not enter retired) Homemaker

15B. KIND OF BUSINESS OR INDUSTRY: Domestic

15C. NAME AND LOCALITY OF COMPANY OR FIRM: Own Residence

16A. RESIDENCE: (State or Country if not USA) New York

16B. County or Region/Province if not USA: Suffolk

16C. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☒ TOWN ☐ West Islip

16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES ☐ NO ☒ IF NO, SPECIFY TOWN:

16D. STREET AND NUMBER OF RESIDENCE: 7 Oak Neck Lane

16E. ZIP CODE: 11795

Islip

17. NAME OF FATHER: FIRST Michael MI LAST Kapey

18. MAIDEN NAME OF MOTHER: FIRST Anelia MI LAST Stanak

19A. NAME OF INFORMANT: Claire J. Long

19B. MAILING ADDRESS: (include zip code) 1720 Wickham Way, Crofton, MD 21114

DISPOSITION

20A. 1 ☒ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT MONTH 01 DAY 24 YEAR 2009

20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Mt. St. Mary's Cemetery

20C. LOCATION: (City or town and state) Flushing, NY

21A. NAME AND ADDRESS OF FUNERAL HOME: Fredrick J. Chapey & Sons, 1225 Montauk Hwy., West Islip, NY 11795

21B. REGISTRATION NUMBER: 00632

22A. NAME OF FUNERAL DIRECTOR: John A. Bernius, Jr.

22B. SIGNATURE OF FUNERAL DIRECTOR:

22C. REGISTRATION NUMBER: 00270

23A. SIGNATURE OF REGISTRAR: Lorraine Scoulis

23B. DATE FILED: MONTH 01 DAY 23 YEAR 2009

24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Lorraine Scoulis

24B. DATE ISSUED: MONTH 01 DAY 23 YEAR 2009

CERTIFIER

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

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: STEPHEN BORNHEIMER License No.: 102304 Signature: Month 1 Day 22 Year 2009
Certifier's Title: 0 ☒ Attending Physician 0 ☐ Physician acting on behalf of Attending Physician 1 ☐ Coroner 2 ☐ Medical Examiner / Deputy Medical Examiner Address: West Islip, N.Y.

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:

26A. Attending physician attended deceased: FROM Month 12 Day 17 Year 2008 TO Month 1 Day 20 Year 2009

26B. Deceased last seen alive by attending physician: Month 1 Day 19 Year 2009

26C. Pronounced Dead ON Month 1 Day 20 Year 2009 AT Time 1107 PM

27. MANNER OF DEATH: NATURAL CAUSE ☒ 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

CAUSE OF DEATH

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

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) Cardiopulmonary arrest — Seconds
DUE TO OR AS A CONSEQUENCE OF:
(B)
DUE TO OR AS A CONSEQUENCE OF:
(C)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): pericardial effusion, Hypertension

DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☐ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ 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

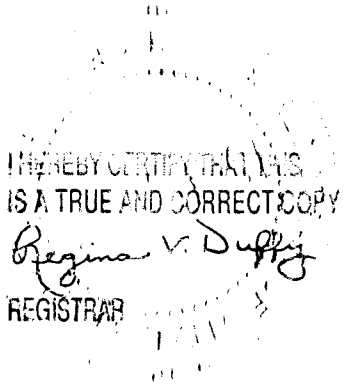
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian

32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? 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

For use by physician or institution:
NAME OF DECEDENT:
DATE OF DEATH:
TIME OF DEATH: AM/PM


I HEREBY CERTIFY THAT THIS
IS A TRUE AND CORRECT COPY
REGISTRAR