

LOCAL REGISTRAR'S CERTIFICATION OF DEATH

WARNING: It is illegal to duplicate this copy by photostat or photograph.

Fee for this certificate, \$6.00



This is to certify that the information here given is correctly copied from an original Certificate of Death duly filed with me as Local Registrar. The original certificate will be forwarded to the State Vital Record Office for permanent filing.

Angela Lynn Smith

JUN 03 2010

Local Registrar

Date Issued

P 16318132

Certification Number

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

CERTIFICATE OF DEATH

(See instructions and examples on reverse)

STATE FILE NUMBER

H105-143 REV. 11/2006
TYPE: PRINT IN
PERMANENT
BLACK INK

1. Name of Decedent (First, middle, last, suffix) Dorothy S. Harm				2. Sex Female		3. Social Security Number 1 6 7 - 0 3 - 7 5 4 2		4. Date of Death (Month, day, year) June 3, 2010			
5. Age (Last Birthday) 93 Yrs.		Under 1 year Months: _____ Days: _____		Under 1 day Hours: _____ Minutes: _____		6. Date of Birth (Month, day, year) July 29, 1916		7. Birthplace (City and state or foreign country) Pittsburgh, Penna.			
8a. Place of Death (Check only one) <input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> ER / Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other - Specify: _____		8b. County of Death Allegheny		8c. City, Boro, Twp. of Death Moun Lebanon Twp.		8d. Facility Name (If not institution, give street and number) Asbury Heights		9. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
10. Race: American Indian, Black, White, etc. (Specify) White		11. Decedent's Usual Occupation (Kind of work done during most of working life. Do not state retired) Kind of Work: Homemaker Kind of Business / Industry: Domicile		12. Was Decedent ever in the U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Decedent's Education (Specify only highest grade completed) Elementary / Secondary (0-12): 12 College (1-4 or 5+): _____		14. Marital Status: Married, Never Married, Widowed, Divorced (Specify) Widowed			
15. Surviving Spouse (If wife, give maiden name) Richard S. Harm [Deceased]		16. Decedent's Mailing Address (Street, city / town, state, zip code) 330 Questend Avenue Pittsburgh, Pennsylvania 15228		17a. State Pennsylvania		17b. County Allegheny		17c. Did Decedent Live in a Township? <input checked="" type="checkbox"/> Yes, Decedent Lived in Mount Lebanon Twp. <input type="checkbox"/> No, Decedent Lived within Actual Limits of _____ City / Boro			
18. Father's Name (First, middle, last, suffix) George Strong				19. Mother's Name (First, middle, maiden surname) Letitia Calhoun							
20a. Informant's Name (Type / Print) Deborah Boisvert				20b. Informant's Mailing Address (Street, city / town, state, zip code) 330 Questend Avenue, Pittsburgh, Pennsylvania 15228							
21a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Removal from State <input type="checkbox"/> Other - Specify: _____		<input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation Was Cremation or Donation Authorized by Medical Examiner / Coroner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		21b. Date of Disposition (Month, day, year) June 7, 2010		21c. Place of Disposition (Name of cemetery, crematory or other place) Pittsburgh Cremation Service		21d. Location (City / town, state, zip code) Pittsburgh, Penna. 15237			
22a. Signature of Funeral Service Licenses (or performing such) <i>Makel J. ...</i>		22b. License Number FD-012822-L		22c. Name and Address of Facility Laughlin Memorial Chapel, 222 Washington Road, Pittsburgh, PA 15216							
23a. Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.		23b. To the best of my knowledge, death occurred at the time, date and place stated. (Signature and title) _____		23c. License Number		23d. Date Signed (Month, day, year)					
24. Time of Death 7 : 3 5 A.M.		25. Date Pronounced Dead (Month, day, year) June 3, 2010		26. Was Case Referred to Medical Examiner / Coroner for a Reason Other than Cremation or Donation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
<p>CAUSE OF DEATH (See instructions and examples)</p> <p>Item 27. 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. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration</p> <p>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.</p> <p>a. Aspiration</p> <p>b. Alzheimers</p> <p>c. _____</p> <p>d. _____</p>											
28. Did Tobacco Use Contribute to Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		29. If Female: <input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		30a. Was an Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30b. Were Autopsy Findings Available Prior to Completion of Cause of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		31. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not be Determined		32a. Date of Injury (Month, day, year)	
32b. Describe How Injury Occurred		32c. Date of Injury		32d. Time of Injury M. <input type="checkbox"/> Yes <input type="checkbox"/> No		32e. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		32f. If Transportation Injury (Specify) <input type="checkbox"/> Driver / Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian Other - Specify: _____		32g. Location of injury (Street, city / town, state)	
32h. Place of Injury: Home, Farm, Street, Factory, Office Building, etc. (Specify)		33a. Certifier (check only one) • Certifying physician (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> • Pronouncing and certifying physician (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> • 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 as stated. <input type="checkbox"/>		33b. Signature and Title of Certifier <i>David A. Nace M.D.</i>		33c. License Number MD051822L		33d. Date Signed (Month, day, year) June 3, 2010			
34. Name and Address of Person Who Completed Cause of Death (Item 27) Type / Print DAVID A. NACE M.D.		35. Registrar's Signature and District Number <i>Angela Lynn Smith</i>		36. Date Filed (Month, day, year) 6/3/10		37. Disposition Permit No. 0 4 8 5 8 3 3					

ALIAS USED: HARM, Dorothy S.