

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

Fee for this certificate, \$2.00



Rona Metzger

Local Registrar

2086065

OCT. 22 1993

No.

Date

pv. 2/87

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS
CERTIFICATE OF DEATH

1. NAME OF DECEDENT (First, Middle, Last) RICHARD S. HARM		2. SEX MALE	3. SOCIAL SECURITY NUMBER 167-07-0093	4. DATE OF DEATH (Month, Day, Year) OCT. 20, 1993
5. AGE (Last Birthday) 81 Yrs.	6. DATE OF BIRTH (Month, Day, Year) JAN. 27, 1912	7. BIRTHPLACE (City and State or Foreign Country) HARRISBURG, PA	8. PLACE OF DEATH (Check only one - see instructions on other side) HOSPITAL: Inpatient <input type="checkbox"/> EFO/patient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <input type="checkbox"/>	
9. COUNTY OF DEATH ALLEGHENY	10. CITY, BORO, TWP OF DEATH BALDWIN	11. FACILITY NAME (If not institution, give street and number) BALDWIN HEALTH CENTER		12. WAS DECEDENT OF HISPANIC ORIGIN? No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> If yes, specify Cuban, Mexican, Puerto Rican, etc.
13. DECEDENT'S USUAL OCCUPATION ELEC. ENGINEER		14. DECEDENT'S EDUCATION (Specify highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4		15. MARITAL STATUS - Married <input type="checkbox"/> Never Married, Widowed, Divorced (Specify) <input checked="" type="checkbox"/> UNMARRIED
16. DECEDENT'S MAILING ADDRESS (Street, City/Town, State, Zip Code) 3220 CHURCHVIEW AVE. PGH, PA 15227		17. DECEDENT'S ACTUAL RESIDENCE (See instructions on other side) 17a. State PA 17b. County ALLEGHENY		18. RACE - American Indian, Black, White, etc. (Specify) WHITE
19. FATHER'S NAME (First, Middle, Last) FREDRICK HARM		20. MOTHER'S NAME (First, Middle, Maiden Surname) SARA JANE OWENS		21. SURVIVING SPOUSE (If wife, give maiden name) DOROTHY STRONG
22. INFORMANT'S NAME (Type/Print) DOROTHY HARM		23. INFORMANT'S MAILING ADDRESS (Street, City/Town, State, Zip Code) 3220 CHURCHVIEW AVE. PGH, PA 15227		24. PLACE OF DISPOSITION - Name of Cemetery, Crematory or Other Place JEFFERSON MEMORIAL PARK
25. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) <input type="checkbox"/>		26. DATE OF DISPOSITION (Month, Day, Year) OCT. 23, 1993		27. LOCATION - City/Town, State, Zip Code PLEASANT HILLS PA 15124
28. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>		29. LICENSE NUMBER 2610357C		30. NAME AND ADDRESS OF FACILITY READSHAW FUNERAL HOME PGH, PA 15210
31. Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.		32. To the best of my knowledge, death occurred at the time, date and place stated. 23a. TIME OF DEATH 2:15 P.M. 23b. DATE PRONOUNCED DEAD (Month, Day, Year) 10/20/93		33. LICENSE NUMBER 2610357C 23c. DATE SIGNED (Month, Day, Year)
34. Items 24-26 must be completed by person who pronounces death.		35. 27. PART I: Enter the diseases, injuries or complications which 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. Coronary Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): a. Coronary Arteriosclerosis b. Coronary Arteriosclerosis c. Coronary Arteriosclerosis d. Coronary Arteriosclerosis		36. 26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
37. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Arteriosclerosis		38. PART II: Other significant conditions contributing to death, but not resulting in the underlying cause given in PART I.		39. Approximate interval between onset and death
40. WAS AN AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	41. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	42. MANNER OF DEATH Natural <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/>	43. DATE OF INJURY (Month, Day, Year)	44. TIME OF INJURY
45. 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.....		46. DATE OF INJURY (Month, Day, Year)		47. INJURY AT WORK? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
48. *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.....		49. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		50. DESCRIBE HOW INJURY OCCURRED.
51. *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.....		52. LOCATION (Street, City/Town, State)		53. SIGNATURE AND TITLE OF CERTIFIER [Signature]
54. REGISTRAR'S SIGNATURE AND NUMBER <i>Rona Metzger</i> 10210357		55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) Type or Print TOM C. SCHAEFER CASTLE VILLAGE PGH, PA 15234		56. DATE SIGNED (Month, Day, Year) 10/20/93
57. REGISTRAR'S SIGNATURE AND NUMBER <i>Rona Metzger</i> 10210357		58. DATE FILED (Month, Day, Year) OCT 22 1993		59. DATE SIGNED (Month, Day, Year) 10/20/93