CERTIFICATION OF VITAL RECORD

OFFICE OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Delaware (107)

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

State File Number 10 004280

1. DECEDENT'S LEGAL NAME (Include AKA's, if any) (First, Middle, Last): Lois A Landing
2. SEX: Female
3. SOCIAL SECURITY NUMBER:
4a. AGE-Last Birthday (Years): 76
4b. UNDER 1 YEAR Months: Days:
4c. UNDER 1 DAY Hours: Minutes:
5. DATE OF BIRTH (Mo/Day/Yr): 11/28/1933
6. BIRTHPLACE (City and State or Foreign Country): Virginia
7a. RESIDENCE-STATE: Delaware
7b. COUNTY: Kent
7c. CITY OR TOWN: Dover
7d. STREET AND NUMBER: 119 Howe Drive
7e. APT. NO.:
7f. ZIP CODE: 19901
7g. INSIDE CITY LIMITS? ☒ Yes ☐ No
8. EVER IN US ARMED FORCES? ☐ Yes ☒ No
9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☒ Widowed ☐ Divorced ☐ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If Wife, give name prior to first marriage):
11. FATHER'S NAME (First, Middle, Last): Esley Taylor
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Lola Cropper Boole
13a. INFORMANT'S NAME: Deborah Schucker
13b. RELATIONSHIP TO DECEDENT: Daughter
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): 937 Sunset Terrace Dover, Delaware 19904

To Be Completed/Verified By: FUNERAL DIRECTOR

14. PLACE OF DEATH (Check only one; see instructions)
IF DEATH OCCURRED IN HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☒ Other (Specify) Health care provider
15. FACILITY NAME (If not institution, give street and number): 9 Baker Drive
16. CITY OR TOWN, STATE AND ZIP CODE: Lincoln, Delaware 19960
17. COUNTY OF DEATH: Sussex
18. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from state ☐ Other (Specify)
19. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place): Downings Cemetery
20. LOCATION-CITY, TOWN AND STATE: Oak Hall, Virginia
21. NAME AND ADDRESS OF FUNERAL FACILITY: Torbert Funeral Chapel
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT: Gary J Wallick (Electronically Verified)
23. LICENSE NUMBER (Of Licensee): K1-0000528
61 S. Bradford St Dover, DE 19904

NAME OF DECEDENT: Lois A Landing
For use by physician or institution

ITEMS 24-49 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr): 08/01/2010
25. TIME PRONOUNCED DEAD: 01:58 AM
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable): Jenny Brown
27. LICENSE NUMBER: L10028009
28. DATE SIGNED (Mo/Day/Yr): 8/1/2010
29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month):
30. ACTUAL OR PRESUMED TIME OF DEATH:
31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events - disease, injuries, or complications - that directly caused the death. DO NOT enter terminal events cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval Onset to death
IMMEDIATE CAUSE (Final disease or condition → resulting in death) a.	CVA	
Due to (or as a consequence of):		
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 b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		
Due to (or as a consequence of):		

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
HTN
melanoma

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No ☐ Unk
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No ☐ Unk

To Be Completed By: MEDICAL CERTIFIER

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☒ Unknown
36. IF FEMALE: ☒ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to one year before death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined
38. DATE OF INJURY (Spell Month):
39. TIME OF INJURY:
40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area):
41. INJURY AT WORK? ☐ Yes ☐ No
42. LOCATION OF INJURY: State: City or Town: County: Street & Number: Apartment Number: Zip Code:
43. DESCRIBE HOW INJURY OCCURRED:
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

45. CERTIFIER (Check only one)
☒ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing and Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated
☐ Coroner/Medical Examiner-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 stated

Signature of certifier:

46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): BM Lenz MD 725 S Queen St Dover DE 19904
47. TITLE OF CERTIFIER: MD
48. LICENSE NUMBER: C1000148
49. DATE CERTIFIED (Mo/Day/Yr): 8/3/10
50. FOR REGISTRAR ONLY- DATE FILED (MM/DD/YYYY): AUG 3 2010

51. DECEDENT'S EDUCATION- Check the box that best describes the highest degree or level of school completed at the time of death: ☐ 8th grade or less
52. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino/ Latina. Check the "No" box if decedent is not Spanish/Hispanic/Latino/ Latina.
53. DECEDENT'S RACE-(Check one or more races to indicate what the decedent considered himself or herself to be): ☒ White ☐ Black or African American ☐ American Indian or Alaska Native

L819997

Amendment Code

This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Delaware Division of Public Health.

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M T Rattay MD

State Registrar

GREAT SEAL OF THE STATE OF DELAWARE 1704 1776 1787

DELAWARE HEALTH AND SOCIAL SERVICES STATE OF DELAWARE

American Bank Note Company

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE