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I HEREBY CERTIFY THAT THE ATTACHED IS A TRUE COPY OF A  
RECORD ON FILE IN THE DIVISION OF VITAL RECORDS.

DATE ISSUED: **May 13, 1991**

*Janice E. Sanderson-Rovell*  
STATE REGISTRAR OF VITAL RECORDS

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (Print, Middle, Last) <b>ROBERT S. SMITH JR.</b>		3. DATE OF DEATH MONTH <b>05</b> DAY <b>12</b> YEAR <b>91</b>		4. TIME OF DEATH <b>10:30 P</b>	
4. SOCIAL SECURITY NUMBER <b>217-24-4106</b>		5. SEX <b>M</b>		6. AGE (In yrs. last birthday) <b>60</b> YRS.	
7. DATE OF BIRTH MONTH <b>06</b> DAY <b>15</b> YEAR <b>30</b>		8. BIRTHPLACE (State or Foreign Country) <b>MASSACHUSETTS</b>			
9. FACILITY NAME (If not institution, give street and number) <b>307 WILLIAMS ROAD</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		11. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
12. STATE <b>MARYLAND</b>		13. COUNTY <b>ANNE ARUNDEL</b>		14. RESIDE CITY (LIMITS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15. STREET AND NUMBER <b>307 WILLIAMS ROAD</b>		16. ZIP CODE <b>21061</b>		17. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If YES, GIVE YEAR OR DATES <b>KOREAN</b>		20. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
21. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>0</b>		22. DECEASED'S USUAL OCCUPATION (Give brief work done during most of working life. Do NOT use abbrev.) <b>INSPECTOR</b>		23. KIND OF BUSINESS/INDUSTRY <b>ELECTRONIC SYSTEMS MFG</b>	
24. FATHER'S NAME (Print, Middle, Last) <b>ROBERT S. SMITH SR.</b>			25. MOTHER'S NAME (Print, Middle, Surname) <b>BELLE ARLENE MEYERS</b>		
26. INFORMANT'S NAME (Print) <b>ANITA THIESSEN SMITH</b>		27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>307 WILLIAMS ROAD - GLEN BURNIE, MD. 21061</b>			
28. MANNER OF DEPOSITION <input type="checkbox"/> Natural <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE OF DEPOSITION (Name of cemetery, crematory or other place) <b>NEW CATHEDRAL</b>		30. LOCATION - City or Town, State <b>BALTIMORE, MD.</b>	
31. SIGNATURE OF REGISTRAR (SERVICE LICENSE) <i>Darryl L. Kaufman</i>		32. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>			
33. PART I. Enter the disease(s) or complication(s) that 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>METASTATIC ADENOCARCINOMA TO BONE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>PROSTATE CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitarily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
34. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
35. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOR OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
37. NUMBER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		38. DATE OF INJURY (Month, Day, Year)		39. TIME OF INJURY	
40. DATE OF INJURY AT WORK <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		41. DESCRIBE HOW INJURY OCCURRED			
42. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		43. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
44. CERTIFY (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> 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 as stated.					
45. SIGNATURE AND TITLE OF CERTIFIER <i>Eva Zinreich</i>		46. LICENSE NUMBER <b>D17173</b>		47. DATE SIGNED (Month, Day, Year) <b>05/13/91</b>	
48. NAME AND ADDRESS OF PHYSICIAN WHO COMPLETED CAUSE OF DEATH (Item 37) (Type PPO) <b>EVA ZINREICH M.D. 6701 N. CHARLES STREET, BALTIMORE, MARYLAND 21204</b>					
49. DATE PREPARED (Month, Day, Year) <b>MAY 13 1991</b>		50. REGISTRAR'S SIGNATURE <i>Janice E. Sanderson-Rovell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The use of this certificate is optional unless a death occurs in a hospital or nursing home. Page 6 may be obtained by the funeral or attending physician. TO THE FUNERAL DIRECTOR: This certificate may be used for the attending physician and coroner's office. It is the funeral director's responsibility to ensure that the certificate is properly completed. Page 5 should be attached to this certificate. TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE: This certificate is required for the State Department of Health and Mental Hygiene. It is the funeral director's responsibility to ensure that the certificate is properly completed. Page 5 should be attached to this certificate. IMPORTANT: If Item 28 is completed, Item 23 should also be completed. The medical examiner must be notified of death.