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STATE OF ILLINOIS CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. <u>16.31</u>		STATE FILE NUMBER	
LOCAL FILE NUMBER <u>335</u>			
1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) <u>Edward S. Worthington JR.</u>		2. SEX <u>male</u>	3. DATE OF DEATH (Month/Day/Year) (Spell Month) <u>December 17, 2009</u>
4. COUNTY OF DEATH <u>Cook</u>	5a. AGE AT LAST BIRTHDAY (Years) <u>88</u>	5b. UNDER 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hours _____ Minutes _____
7a. CITY OR TOWN <u>Blue Island</u>		7b. HOSPITAL OR OTHER INSTITUTION NAME (if not in either, give street and number) <u>Metro South Hospital</u>	
7c. PLACE OF DEATH (Check only one: see instructions)			
IF DEATH OCCURRED IN A HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival		IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing Home/Long-term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify): _____	
8. BIRTHPLACE (City and State or Foreign Country) <u>Parksville KY</u>	9. SOCIAL SECURITY NUMBER <u>[REDACTED] .1518</u>	10. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married but separated <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	11. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage) <u>NONE</u>
12. EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
13a. RESIDENCE (Street and Number) <u>12808 Lincoln</u>	13b. APT. NO.	13c. CITY OR TOWN <u>Blue Island</u>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13e. COUNTY <u>COOK</u>	13f. STATE <u>IL</u>	13g. ZIP CODE <u>60406</u>	
14. FATHER'S NAME (First, Middle, Last) <u>Edward S. Worthington SR</u>		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) <u>Elizabeth Shannon</u>	
16a. INFORMANT'S NAME <u>MARY DOBERSTEIN</u>		16b. RELATIONSHIP <u>DAUGHTER</u>	
17. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify): _____		18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) <u>Holy Sepulchre</u>	
19. LOCATION - CITY, TOWN AND STATE <u>Worth Twp. IL</u>		20. DATE OF DISPOSITION (Month/Day/Year) <u>Dec. 21, 2009</u>	
21a. FUNERAL HOME NAME <u>Hickey Memorial Chapel</u>		21b. FUNERAL HOME STREET AND NUMBER <u>2429 W. 127th Blue Island IL</u>	
21c. CITY OR TOWN <u>Blue Island IL</u>		21d. STATE <u>IL</u>	
21e. ZIP <u>60406</u>		21f. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER <u>034-011598</u>	
22. LOCAL REGISTRAR'S SIGNATURE <u>[Signature]</u>		23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) <u>Dec - 22, 2009</u>	
24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hypertension</u> Due to (or as a consequence of):			<u>10 year</u>
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			<u>10 year</u>
b. <u>Chronic Pulmonary Lung Disease</u> Due to (or as a consequence of):			<u>7 year</u>
c. <u>Stroke</u> 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.			
25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	28. IF FEMALE: <input type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Pregnant within one year of death but time unknown <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within one year of death		29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation
30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
34. LOCATION OF INJURY Street and Number Apartment Number City or Town State ZIP Code			
35. DESCRIBE HOW INJURY OCCURRED:			36. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)
37. (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON <u>12-7-09</u>		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	39. DATE PRONOUNCED (Month/Day/Year) <u>12-7-09</u>
40. TIME OF DEATH <u>07:35 A.M.</u>			
41. CERTIFIER (Check only one): <input type="checkbox"/> Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input 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 stated.			43. PHYSICIAN'S LICENSE NUMBER <u>036-081654</u>
42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) <u>11250 Western, Chicago Ill 60643</u>			
44. TITLE OF CERTIFIER <u>MD</u>		45. DATE CERTIFIED (Month/Day/Year) <u>12-21-09</u>	46. SIGNATURE OF CERTIFIER <u>[Signature]</u>

This is to certify that this is a true and correct copy of the official death record filed with the Illinois Department of Public Health.

DEC 22 2009

[Signature]

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PIN: 25-31-207-041-0000

LEGAL: THE SOUTH ½ OF LOT 3 AND ALL OF LOT 4 IN BLOCK 6 IN BLUE ISLAND SUPPLEMENT A SUBDIVISION OF THE NORTHWEST ¼ OF SECTION 31, TOWNSHIP 37 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS

Property of Cook County Clerk's Office