OFFICE of VITAL STATISTICS

CERTIFIED COPY

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CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO

- 1 DECEDENT'S NAME (First, Middle, Last): BRYCE E. VAUGHN
- 2 SEX: MALE
- 3 DATE OF DEATH (Month, Day, Year): APRIL 27, 1998
- 4 SOCIAL SECURITY NUMBER: 405-09-5265
- 5a AGE Last Birthday (years): 80
- 5b UNDER 1 YEAR (Months, Days):
- 5c UNDER 1 DAY (Hours, Minutes):
- 6 DATE OF BIRTH (Month, Day, Year): NOVEMBER 3, 1917
- 7 BIRTHPLACE (City and State or Foreign Country): LIVINGSTON COUNTY, KENTUCKY
- 8 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No): NO
- 9a PLACE OF DEATH (Check only one; see instructions on other side): HOSPITAL X Inpatient _ ER/Outpatient _ DOA; OTHER _ Nursing Home _ Residence _ Other (Specify)
- 9b INSIDE CITY LIMITS? (Yes or No): YES
- 9c FACILITY NAME (If not institution, give street and number): CHARLOTTE REGIONAL MEDICAL CENTER
- 9d CITY, TOWN, OR LOCATION OF DEATH: PUNTA GORDA
- 9e COUNTY OF DEATH: CHARLOTTE
- 10a DECEDENT'S USUAL OCCUPATION: QUALITY ASSURANCE
- 10b KIND OF BUSINESS/INDUSTRY: STEEL
- 11 MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify): MARRIED
- 12 SURVIVING SPOUSE (If wife, give maiden name): BARBARA M. AUDO
- 13a RESIDENCE – STATE: INDIANA
- 13b COUNTY: LAKE
- 13c CITY, TOWN, OR LOCATION: HOBART
- 13d STREET AND NUMBER: 318 6TH STREET
- 13e INSIDE CITY LIMITS? (Yes or No): YES
- 13f ZIP CODE: 46342
- 14 WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes – If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.): X No _ Yes; Specify
- 15 RACE – American Indian, Black, White, etc. (Specify): WHITE
- 16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):
- 17 FATHER'S NAME (First, Middle, Last): WILLIAM BASIL VAUGHN
- 18 MOTHER'S NAME (First, Middle, Maiden Surname): RUTHA JOHNSON
- 19a INFORMANT'S NAME (Type/Print): BARBARA M. VAUGHN
- 19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 318 6TH STREET, HOBART, INDIANA 46342
- 20a METHOD OF DISPOSITION: _ Burial _ Cremation X Removal from State _ Donation _ Other (Specify)
- 20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): CALUMET PARK
- 20c LOCATION – City or Town, State: MERRILLVILLE, INDIANA
- 21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: [signature]
- 21b LICENSE NUMBER (of Licensee): FE1644
- 21c NAME AND ADDRESS OF FACILITY: KAYS-PONGER/ROYAL PALM FUNERAL HOME 635 E. MARION AVE. PUNTA GORDA, FL. 33950
- 22a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. (Signature and Title): [signature]
- 22b DATE SIGNED (Mo., Day, Yr.): Apr. 28, 1998
- 22c HOUR OF DEATH: 10:50 A.M.
- 22d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):
- 23a 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 (Signature and Title):
- 23b DATE SIGNED (Mo., Day, Yr.):
- 23c HOUR OF DEATH: M
- 23d MEDICAL EXAMINER'S CASE #:
- 24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print): SAMUEL ESTEPA M.D. 713 E. MARION AVE. PUNTA GORDA, FLORIDA 33950
- 25a SUBREGISTRAR – SIGNATURE AND DATE:
- 25b LOCAL REGISTRAR – SIGNATURE: Loren H. Johnson, Deputy
- 25c DATE REGISTERED: April 29, 1998

26 PART I. Enter the diseases, injuries, or complications 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. (Approximate Interval Between Onset and Death)

- IMMEDIATE CAUSE (Final disease or condition resulting in death): a. CARDIO-PULMONARY ARREST
- DUE TO (OR AS A CONSEQUENCE OF): b. END STAGE CARDIOMYOPATHY
- DUE TO (OR AS A CONSEQUENCE OF): c. CHRONIC ATRIAL FIBRILLATION
- DUE TO (OR AS A CONSEQUENCE OF): d. ASHD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

- PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: CORONARY ARTERY DISEASE, HYPERTENSION, S/P SURGERY
- 27a WAS AN AUTOPSY PERFORMED? (Yes or No): NO
- 27b WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No):
- 28 CASE REPORTED TO MEDICAL EXAMINER? (Yes or No): NO
- 29 IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? _ YES _ NO
- 30a IF SURGERY IS MENTIONED IN PART I OR II ENTER CONDITION FOR WHICH IT WAS PERFORMED: R COLON RESECTION, ADENOCARCINOMA; CHOLECYSTECTOMY & ABSCESS DRAINAGE
- 30b DATE OF SURGERY (Mo., Day, Year): MARCH 19, 1998; APRIL 13, 1998
- 31 PROBABLE MANNER OF DEATH (Specify) Natural, accident, suicide, homicide, or undetermined: NATURAL
- 32a DATE OF INJURY (Month, Day, Year):
- 32b TIME OF INJURY: M
- 32c INJURY AT WORK? (Yes or No):
- 32d DESCRIBE HOW INJURY OCCURRED:
- 32e PLACE OF INJURY – At home, farm, street, factory, etc. (Specify):
- 32f LOCATION (Street and Number or Rural Route Number, City or Town, State):

DH 512, 9/96 (Replaces HRS Form 512)

Rees Funeral Home
P.O.B. 488
Hobart 46342

FILED
JUN 03 1998
SAM ORLICH
AUDITOR LAKE COUNTY

APRIL 30, 1998

900 Ck#26709

STATE FILE NO. 98-015631

VOID IF ALTERED OR ERASED

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THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

Charlotte County Dept. of Health 20101 Peachland Bl. Ste. 208, Port Charlotte, FL 33954

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BY Christine J. Machintonio, Deputy — State Registrar

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HRS FORM 1564A (9-96)

CERTIFICATION OF VITAL RECORD

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