VS-4ME 4/04
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH
OFFICE OF THE CHIEF MEDICAL EXAMINER

STATE FILE NUMBER

1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last)	2. SEX	3. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) (Spell Month)	4. ACTUAL OR PRESUMED TIME OF DEATH
Anthony Chia-Hua Hsieh	☒ MALE ☐ FEMALE	November 27, 2020	5:04 AM

5. Age at last birthday	6. Under 1 Year Under 1 Day Mo. Days Hours Min	7. Date of Birth (MM/DD/YYYY)	8. BIRTHPLACE (City, State or Foreign County)
46		12/12/1973	Urbana, Illinois

9. RESIDENCE-STATE	10. RESIDENCE-COUNTY	11. RESIDENCE- CITY OR TOWN
Nevada	Clark	Las Vegas

12. RESIDENCE- STREET AND NO.	13. APT NO.	14. ZIP CODE	15. EVER IN US ARMED FORCES?	16. MARITAL STATUS AT TIME OF DEATH	17. SURVIVING SPOUSE'S NAME (if wife, give maiden name)
[redacted]	**	89141	☐ Yes ☒ No	☐ Married ☐ Married but Separated ☐ Widowed ☐ Divorced ☒ Never Married ☐ Unknown	N/A

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)
Richard Hsieh	Judy Lee

20. INFORMANT'S NAME	21. INFORMANT'S RELATIONSHIP TO DECEDENT	22. MAILING ADDRESS (Street and Number, City, State, Zip Code)
Richard Hsieh	Father	[redacted]

23. IF DEATH OCCURRED IN A HOSPITAL:	24. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL	25. FACILITY NAME (If not institution, give street & number)
☒ Inpatient ☐ ER/outpatient ☐ Dead on Arrival	☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Other (specify)	Bridgeport Hospital

26. CITY OR TOWN OF DEATH & ZIP CODE	27. COUNTY OF DEATH	28. METHOD OF DISPOSITION:
Bridgeport 06610	Fairfield	☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from state ☐ Other (specify)

29. DISPOSITION (Name of cemetery, crematory, other place)	30. LOCATION (city/town) (state)	31. DATE (MM/DD/YYYY)	32. WAS BODY EMBALMED?	33. FUNERAL FACILITY - Name and Address (street, town, state, zip)
Lakeview Crematory	Bridgeport, CT	12/01/2020	☒ Yes ☐ No If Yes, Name of Embalmer: Ryan Boulerice	[redacted]

34. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER	35. LICENSE NUMBER of SIGNEE IN BOX 34
James S. Arnold	2320

36. M.E. CASE NUMBER	37. DATE PRONOUNCED DEAD (MM/DD/YYYY)	38. TIME PRONOUNCED	39. WAS AN AUTOPSY PERFORMED?
20-26866	11/27/2020	5:04 AM	☒ Yes ☐ No

CAUSE OF DEATH

40. 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 the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)——▸

(a) **Pending Further Studies**

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) _____

APPROXIMATE INTERVAL ONSET TO DEATH

41. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I	42. IF FEMALE: ☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at the time of death ☐ Unknown if pregnant within past year ☐ Not pregnant, but pregnant within 42 days of death	43. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☒ Unknown

44. MANNER OF DEATH (Natural, Homicide, Accident, Suicide, Undetermined, Specify)	45. DATE OF INJURY (Spell Month) (Month DD YYYY)	46. TIME OF INJURY	47. PLACE OF INJURY (Decedent's home, construction site, wooded area)	48. INJURY AT WORK?
Pending				☐ Yes ☒ No

49. LOCATION OF INJURY (Street, Apt. #, City or Town, State, Zip Code)	50. DESCRIBE HOW INJURY OCCURRED	51. IF TRANSPORTATION INJURY, SPECIFY
		☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other specify

52. CERTIFIER: 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.

Gregory A. Vincent, M.D.		Associate Medical Examiner	Nov 28, 2020
Certifier Name (type or print)	Certifier Signature	Title of Certifier	Date Certified

53. MAILING-CERTIFIER (Street)	(CITY OR TOWN)	(STATE)	(ZIP CODE)
Office of the Chief Medical Examiner, [redacted]			

THIS CERTIFICATE WAS RECEIVED FOR RECORD ON	BY REGISTRAR
NOV 30 2020	Patricia P. Kladowska

Administrative Purposes

54. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.	55. DECEDENT OF HISPANIC ORIGIN?	56. DECEDENT'S RACE
☐ 8th grade or less ☐ 9-12th grade, no diploma ☐ High School Graduate/GED ☐ Some college credit, but no degree ☐ Associate degree ☒ Bachelor degree ☐ Master's degree ☐ Doctorate or Professional degree ☐ Unknown ☐ Not available	☒ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes other Spanish/Hispanic/Latino (specify)	☐ White ☐ Black or African American ☐ Asian Indian ☐ American Indian or Alaska Native (Name of the enrolled or principle tribe) ☒ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (specify) ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (specify) ☐ Other (specify)

57. DECEDENT'S USUAL OCCUPATION	58. KIND OF BUSINESS/INDUSTRY	SOCIAL SECURITY NUMBER
Entrepreneur	Urban Development	