

CERTIFICATE OF DEATH

STATE FILE NUMBER (For State Use only. Do not write in this box)

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) MARY TYLER MOORE				2. SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	3. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) (Spell Month) 01/25/2017	4. ACTUAL OR PRESUMED TIME OF DEATH 1415 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM
5. AGE LAST BIRTHDAY 80	6. UNDER 1 YEAR Mo. Days Hours Min.	7. DATE OF BIRTH (MM/DD/YYYY) 12/29/1936	8. BIRTHPLACE (City, State or Foreign Country) Brooklyn New York			
9. RESIDENCE (State) Connecticut		10. RESIDENCE (County)	11. RESIDENCE (City or Town)	12. RESIDENCE (Street and No.)		13. APT. NO.
14. ZIP CODE	15. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	16. MARITAL STATUS AT TIME OF DEATH: <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		17. SURVIVING SPOUSE'S NAME (Give full name prior to first marriage) S. Robert Levine M.D		
18. FATHER'S NAME (First, Middle, Last) George Tyler Moore			19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Marjorie Hackett			
20. INFORMANT'S NAME S. Robert Levine M.D.		21. INFORMANT'S RELATIONSHIP TO DECEDENT Husband		22. MAILING ADDRESS (Street and Number, City, State, Zip Code)		
23. IF DEATH OCCURRED IN A HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/outpatient <input type="checkbox"/> Dead on Arrival		24. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (specify)		25. FACILITY NAME (If not institution, give street & number) GREENWICH HOSPITAL		
26. CITY OR TOWN OF DEATH GREENWICH 06830		27. COUNTY OF DEATH FAIRFIELD		28. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (specify)		
29. DISPOSITION (Name of cemetery, crematory, other place) Oaklawn Cemetery		30. LOCATION (city/town, state) Fairfield, CT		31. DATE (MM/DD/YYYY) 1/29/2017	32. WAS BODY EMBALMED? If yes, Name of Embalmer <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Stephen Schubert	
33. FUNERAL FACILITY, Name and Address (street, town, state, zip)				34. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER Chilton Ferrer		35. LICENSE NUMBER OF SIGNEE IN BOX 34 2528
36. DATE PRONOUNCED DEAD (MM/DD/YYYY) 01/25/2017		37. TIME PRONOUNCED 1415		38. PRONOUNCER'S NAME AND DEGREE OR TITLE (Print) Dr. JAMES PALLETT MD		39. PRONOUNCER'S SIGNATURE
41. WAS MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		42. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		43. WERE THE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

44. PART I. Enter respiratory arrest

IMMEDIATE CAUSE (Final disease or condition resulting in death)

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

(a) **Cardiopulmonary Arrest**
Due to (or as a consequence of):

(b) **Aspiration pneumonia**
Due to (or as a consequence of):

(c) **Hypoxia**
Due to (or as a consequence of):

(d) **Diabetes Mellitus**

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

46. 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 1 year before death
 Unknown if pregnant within the past year

47. DID TOBACCO USE CONTRIBUTE TO DEATH?
 Yes Probably No Unknown

48. CERTIFIER (Check only one box) Certifying practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge death occurred due to the cause(s) and manner stated.
 Pronouncing & Certifying Practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge death occurred at the time, date and place, and due to the cause(s) stated.

Michael Liu (Certifier Name) **Attending Physician** (Title of Certifier) **1/25/2017** (Date Certified)

Greenwich (City or Town) **CT** (State) **06830** (Zip)

THIS CERTIFICATE WAS RECEIVED FOR RECORD ON: **JAN 30 2017** BY **Lina Murphy, est** REGISTRAR

I HEREBY CERTIFY THAT THE FOREGOING IS A TRUE COPY OF THE RECORD ON FILE IN THE GREENWICH TOWN CLERK'S OFFICE, EXCEPT SUCH INFORMATION THAT IS NONDISCLOSABLE BY LAW, ATTESTED BY THE RAISED SEAL OF THE TOWN OF GREENWICH.

Lina Murphy
ASSISTANT REGISTRAR JANUARY 30, 2017

LEGAL FEE: \$20.00
THIS CERTIFICATE NOT VALID WITHOUT SEAL