

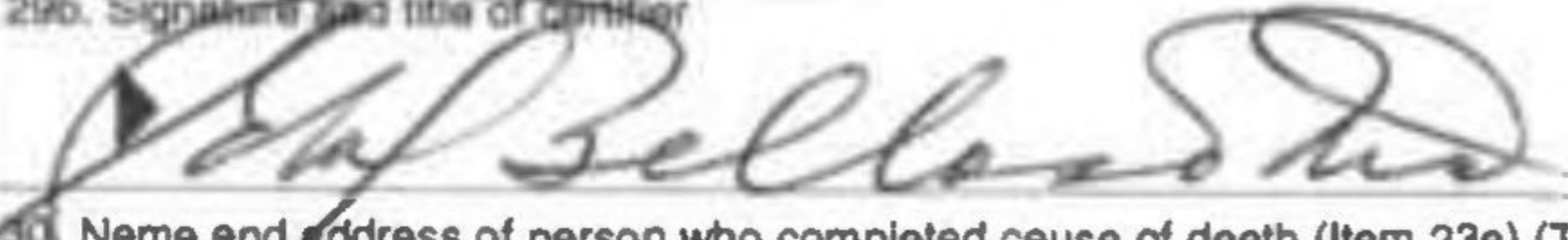
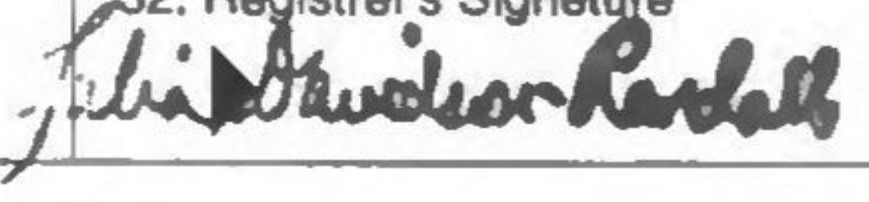
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06628

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH BRUNKHARDT		2. Date of Death Month Day Year FEBRUARY 18 1997		3. Time of Death 2:45 PM	
	4a. Facility Name (If not Institution, give street and number) BERLIN NURSING & REHAB. CTR.		4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 138-58-5873		6. Sex 1 ☐ M 2 ☒ F		7. Age (In yrs. last birthday) 101 Yrs.	
	8. Date of Birth (Month, Day, Year) 11-1-95		9. Birthplace (State or Foreign Country) HOLLAND			
To Be Completed by Funeral Director	10a. State MD.		10b. County WORCESTER		10c. City, Town or Location BERLIN	
	10d. Inside City Limits 1 ☐ Yes 2 ☒ No		10e. Street and Number 17 SUNDIAL CIRCLE		10f. Zip Code 21811	
	10g. Citizen of What Country? USA		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME	
	17. Father's Name (First, Middle, Last) MARINUS DANIELS		18. Mother's Name (First, Middle, Maiden Surname) JACOBA DANIELS			
	19a. Informant's Name/Relationship (Type, Print) BETTY LARSEN		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1448 OCEAN PINES BERLIN, MD., 21811			
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY		20c. Location - City or Town, State 2-19 SALISBURY, MD.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD., 21811			
	23a. Enter the disease, 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. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Generalized Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia. Organic Brain Syndrome Hypertension. Peripheral Vascular Disease. Open Angle Glaucoma. Blindness		Approximate Interval Between Onset and Death 5 yrs. 5 yrs			
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown		24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No		24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No		26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		28a. Date of Injury (Month, Day, Year) 2-18-97		28b. Time of Injury M		
28c. Injury at Work? 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ 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 stated.				
29b. Signature and title of certifier 		29c. License number D29505		29d. Date signed (Month, Day, Year) 2-18-97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GREGORIO BELLOSO, M.D. 5302 CHINABERRY DR. SALISBURY MD 21801						
31. Date filed (Month, Day, Year) FEB 19 1997		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner