CERTIFIED COPY

TYPE 91 PERMANENT BLACK INK

LOCAL FILE NO.

FLORIDA CERTIFICATE OF DEATH

DEMOGRAPHIC INFORMATION TO BE COMPLETED BY: FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last, Suffix): Winifred Mary Goodchild
2. SEX: Female
3. DATE OF BIRTH (Month, Day, Year): February 27, 1937
4a. AGE-Last Birthday (Years): 72
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF DEATH (Month, Day, Year): May 9, 2009
6. SOCIAL SECURITY NUMBER: 118-28-5234
7. BIRTHPLACE (City and State or Foreign Country): New York, New York
8. COUNTY OF DEATH: Broward
9. PLACE OF DEATH (Check only one): HOSPITAL: X Inpatient ___ Emergency Room/Outpatient ___ Dead on Arrival; NON-HOSPITAL: ___ Hospice Facility ___ Nursing Home/Long Term Care Facility ___ Decedent's Home ___ Other (Specify)
10. FACILITY NAME (If not institution, give street address): Memorial Hospital West
11a. CITY, TOWN, OR LOCATION OF DEATH: Pembroke Pines
11b. INSIDE CITY LIMITS? X Yes ___ No
12. MARITAL STATUS (Specify): ___ Married ___ Married, but Separated X Widowed ___ Divorced ___ Never Married
13. SURVIVING SPOUSE'S NAME (If wife, give maiden name):
14a. RESIDENCE - STATE: Florida
14b. COUNTY: Broward
14c. CITY, TOWN, OR LOCATION: Pembroke Pines
14d. STREET ADDRESS: 2271 Dogwood Court
14e. APT. NO.:
14f. ZIP CODE: 33026
14g. INSIDE CITY LIMITS? X Yes ___ No
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired": Clerk
15b. KIND OF BUSINESS/INDUSTRY: Banking
16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.): X White ___ Black or African American ___ American Indian or Alaskan Native (Specify tribe) ___ Asian Indian ___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Vietnamese ___ Other Asian (Specify) ___ Native Hawaiian ___ Guamanian or Chamorro ___ Samoan ___ Other Pacific Isl. (Specify) ___ Other (Specify)
17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.): ___ Yes (If Yes, specify) X No ___ Mexican ___ Puerto Rican ___ Cuban ___ Central/South American ___ Other Hispanic (Specify) ___ Haitian
18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.): ___ 8th or less ___ High school but no diploma X High school diploma or GED ___ College but no degree ___ College degree (Specify): ___ Associate ___ Bachelor's ___ Master's ___ Doctorate
19. WAS DECEDENT EVER IN U.S. ARMED FORCES? ___ Yes X No
20. FATHER'S NAME (First, Middle, Last, Suffix): John F. Dowling
21. MOTHER'S NAME (First, Middle, Maiden Surname): Winifred McCabe
22a. INFORMANT'S NAME: William J. Goodchild, Jr.
22b. RELATIONSHIP TO DECEDENT: Son
23a. INFORMANT'S MAILING - STATE: Virginia
23b. CITY OR TOWN: Manassas
23c. STREET ADDRESS: 8756 Bradley Forge Drive
23d. ZIP CODE: 20112
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Neptune Society Cremtory
25a. LOCATION - STATE: Florida
25b. LOCATION - CITY OR TOWN: Deerfield Beach
26a. METHOD OF DISPOSITION: ___ Burial ___ Entombment X Cremation ___ Donation ___ Removal from State ___ Other (Specify)
26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? X Yes ___ No
27a. LICENSE NUMBER (of Licensee): F044335
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: ▶ William R Sp[illegible]
28. NAME OF FUNERAL FACILITY: Neptune Society
29a. FACILITY'S MAILING - STATE: Florida
29b. CITY OR TOWN: Pompano Beach
29c. STREET ADDRESS: 3404 North Andrews Avenue Extension
29d. ZIP CODE: 33064

MEDICAL CERTIFIER

30. CERTIFIER (Check one): X Certifying Physician - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. ___ Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated.
31a. (Signature and Title of Certifier): ▶ [signature]
31b. DATE SIGNED (mm/dd/yyyy): 05/13/2009
32. TIME OF DEATH (24 hr.): 1015
33. MEDICAL EXAMINER'S CASE NUMBER:
34a. LICENSE NUMBER (of Certifier): ME 81711
34b. CERTIFIER'S NAME: Jose Santiago
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier):
36a. CERTIFIER'S - STATE: Florida
36b. CITY OR TOWN: Pembroke Pines
36c. STREET ADDRESS: 703 North Flamingo Road
36d. ZIP CODE: 33028
37. REGISTRAR - Signature and Date: [signature] 5-15-09
38a. LOCAL REGISTRAR - Signature: ▶ Nalika Lalji
38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.): MAY 18 2009

CAUSE OF DEATH TO BE COMPLETED BY: MEDICAL CERTIFIER

39. PROBABLE MANNER OF DEATH: X Natural; The following are under the jurisdiction of the medical examiner: ___ Accident ___ Suicide ___ Homicide ___ Pending Investigation ___ Undetermined
40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? ___ Yes X No
41. CAUSE OF DEATH - PART I. (See instructions on back) Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology.

	Cause	Approximate Interval: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	PNEUMONIA	days
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.	AMYOTROPHIC LATERAL SCLEROSIS	years
c.		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
42a. WAS AN AUTOPSY PERFORMED? ___ Yes X No
42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ___ Yes ___ No
43a. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY:
43b. DATE OF SURGERY (Mo., Day, Yr.):
44. DID TOBACCO USE CONTRIBUTE TO DEATH? ___ Yes ___ No ___ Probably X Unknown
45. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR: ___ Yes ___ No ___ Unknown; If Yes, specify timeframe: ___ at time of death ___ within 1 to 42 days of death ___ within 43 days to 1 year of death
46. DATE OF INJURY (Month, Day, Year):
47. TIME OF INJURY (24 hr.):
48. INJURY AT WORK? ___ Yes ___ No
49a. LOCATION OF INJURY - STATE:
49b. CITY OR TOWN:
49c. STREET ADDRESS:
49d. APT. NO.:
49e. ZIP CODE:
50. DESCRIBE HOW INJURY OCCURRED:
51. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area):

VOID IF ALTERED OR ERASED
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State of Florida, Department of Health, Vital Statistics
... 2004 (Obsoletes previous editions which may not be used)