OFFICE of VITAL STATISTICS

CERTIFIED COPY

TYPE IN PERMANENT BLACK INK

FLORIDA CERTIFICATE OF DEATH

LOCAL FILE NO.

DECEDENT'S INFORMATION TO BE COMPLETED BY: FUNERAL DIRECTOR (DEMOGRAPHIC INFORMATION)

1. DECEDENT'S NAME (First, Middle, Last, Suffix): William J. Goodchild
2. SEX: Male
3. DATE OF BIRTH (Month, Day, Year): July 13, 1933
4a. AGE-Last Birthday (Years): 73
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF DEATH (Month, Day, Year): July 28, 2006
6. SOCIAL SECURITY NUMBER: 066 26 5327
7. BIRTHPLACE (City and State or Foreign Country): New York City, New York
8. COUNTY OF DEATH: Broward
9. PLACE OF DEATH (Check only one): HOSPITAL: ___ Inpatient ___ Emergency Room/Outpatient ___ Dead on Arrival; NON-HOSPITAL: ___ Hospice Facility ___ Nursing Home/Long Term Care Facility X Decedent's Home ___ Other (Specify)
10. FACILITY NAME (If not institution, give street address): 6327 Brandywine Drive North
11a. CITY, TOWN, OR LOCATION OF DEATH: Margate
11b. INSIDE CITY LIMITS?: X Yes ___ No
12. MARITAL STATUS (Specify): X Married ___ Married, but Separated ___ Widowed ___ Divorced ___ Never Married
13. SURVIVING SPOUSE'S NAME (If wife, give maiden name): Winifred Dowling
14a. RESIDENCE - STATE: Florida
14b. COUNTY: Broward
14c. CITY, TOWN, OR LOCATION: Margate
14d. STREET ADDRESS: 6327 Brandywine Drive North
14e. APT NO:
14f. ZIP CODE: 33063
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": Security Guard
15b. KIND OF BUSINESS/INDUSTRY: Security
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 X High school but no diploma ___ 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?: X Yes ___ No
20. FATHER'S NAME (First, Middle, Last, Suffix): Edward Goodchild
21. MOTHER'S NAME (First, Middle, Maiden Surname): Johanna Walsh
22a. INFORMANT'S NAME: Winifred Goodchild
22b. RELATIONSHIP TO DECEDENT: Wife
23a. INFORMANT'S MAILING - STATE: Florida
23b. CITY OR TOWN: Margate
23c. STREET ADDRESS: 6327 Brandywine Drive North
23d. ZIP CODE: 33063
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Treasure Coast Crematory
25a. LOCATION - STATE: Florida
25b. LOCATION - CITY OR TOWN: Lake Worth
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): 3608
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: [signature]
28. NAME OF FUNERAL FACILITY: Neptune Society
29a. FACILITY'S MAILING - STATE: Florida
29b. CITY OR TOWN: Oakland Park
29c. STREET ADDRESS: 531 E. Oakland Park Blvd.
29d. ZIP CODE: 33334

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): 08/02/06
32. TIME OF DEATH (24 hr): 1055
33. MEDICAL EXAMINER'S CASE NUMBER:
34a. LICENSE NUMBER (of Certifier): 052524
34b. CERTIFIER'S NAME: Dr. Arthur Gomberg
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier): Nelson Vieira MD
36a. CERTIFIER'S - STATE: Florida
36b. CITY OR TOWN: Fort Lauderdale
36c. STREET ADDRESS: 5420 NW 33rd Avenue Suite 100
36d. ZIP CODE: 33309
37. SUBREGISTRAR - Signature and Date: [signature] 8/4/06
38a. LOCAL REGISTRAR - Signature: [signature]
38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.): AUG 07 2006

CAUSE OF DEATH TO BE COMPLETED BY: MEDICAL CERTIFIER

39. PROBABLE MANNER OF DEATH: ___ 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Bronchogenic Carcinoma
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.
c.
d.
Approximate Interval Onset to Death:

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 ✓ 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)

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

VOID IF ALTERED OR ERASED
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