

# Registrar of Vital Statistics

## Certified Copy



THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND - NOT A WHITE BACKGROUND

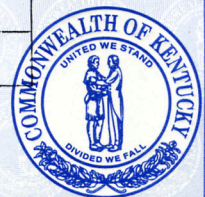
2618616

### COMMONWEALTH OF KENTUCKY CABINET FOR HEALTH & FAMILY SERVICES REGISTRAR OF VITAL STATISTICS CERTIFICATE OF DEATH

116 2001 035299

FORM VS NO. 1-A  
(REV. 7/08)

MUST BE TYPED	1. DECEDENT'S NAME (First, Middle, Last) Carolyn OMOHUNDRO				2. SEX Female	3. DATE OF DEATH (Month, Day, Year) November 27, 2009	
	4. SOCIAL SECURITY NUMBER 401-38-1846		5a. AGE Last Birthday (Years) 76	5b. UNDER 1 YEAR (Months)	5c. UNDER 1 DAY (Hours)	6. DATE OF BIRTH (Month, Day, Year) August 26, 1933	
DECEDENT	7. BIRTHPLACE (City/State or Foreign Country) Montgomery Co. Kentucky		8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
	9a. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
PARENTS	9b. FACILITY NAME (If not institution, give street and number) Windsor Care Center		9c. CITY, TOWN, OR LOCATION OF DEATH Mt. Sterling		9d. COUNTY OF DEATH Montgomery		
	10. MARITAL STATUS Married, Never Married Widowed, Divorced (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name)		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Homemaker		
INFORMANT	12b. KIND OF BUSINESS/INDUSTRY Own Home		13a. RESIDENCE - State Kentucky		13b. COUNTY Bath		
	13c. CITY, TOWN, OR LOCATION Salt Lick		13d. STREET AND NUMBER 10584 East Highway 60		14. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DISPOSITION	15. ZIP CODE 40371		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		17. RACE - American Indian, Black, White, etc. (Specify) White		
	18. FATHER'S NAME (First, Middle, Last) Frank McLean		19. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma Chandler				
CERTIFIER	19a. INFORMANT'S NAME Richard Omohundro (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Zip Code) 10516 East Highway 60, Salt Lick, KY 40371				
	20a. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Jones Cemetery		20c. LOCATION (City, Town, or State) Salt Lick, KY		
CAUSE OF DEATH	21. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such) <i>Robert J. Powell</i> Robert J. Powell KY 4638		DATE SIGNED (Month, Day, Year) 11/30/09		22. NAME AND ADDRESS OF FACILITY Powell Funeral Home, Inc. P.O. Box 294, Salt Lick, KY 40371		
	23a. To the best of my knowledge, death occurred at the time, date, place and due to the causes stated Signature and Title: <i>L. Edward Roberts MD</i> (Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 and KRS 369.118		23b. DATE SIGNED (Month, Day, Year) 12/08/2009				
REGISTRAR	24. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) L. Edward Roberts, MD 100 Sterling Way, #1, Mt. Sterling, KY 40353						
	25. TIME OF DEATH 10:19 AM		26. DATE PRONOUNCED DEAD (Month, Day, Year) November 27, 2009		27. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28. PART I. Enter the diseases, injuries, or complications that caused 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. NOTE: Kentucky data indicate that diabetes is likely underreported on death certificates. If known, document diabetes as a "cause of" or "contributing cause of" death as appropriate in Parts I and II.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Stroke DUE TO (OR AS A CONSEQUENCE OF)							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST b. Cerebral Aneurysm DUE TO (OR AS A CONSEQUENCE OF)							
c. DUE TO (OR AS A CONSEQUENCE OF)							
d. DUE TO (OR AS A CONSEQUENCE OF)							
e. DUE TO (OR AS A CONSEQUENCE OF)							
PART II. Other significant conditions contributed to death but not resulting in the underlying cause given in Part I. Dysphagia, Type 2 Diabetes							
29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined		30a. DATE OF INJURY (Month, Day, Year)		30b. TIME OF INJURY		30c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
30d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		30e. LOCATION (Street and Number or Rural Route Number, City or Town)					
31. REGISTRAR'S SIGNATURE <i>Paul F. Royce</i>		32. DATE FILED (Month, Day, Year) DEC 09 2009					



THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

I, Paul F. Royce, Registrar of Vital Statistics, hereby certify this to be a true and correct copy of the certificate of birth, death, marriage or divorce of the person therein named, and that the original certificate is registered under the file number shown. In testimony thereof I have hereunto subscribed my name and caused the official seal of the Office of Vital Statistics to be affixed at Frankfort, Kentucky this 09 day of December, 2009.

*Paul F. Royce*