

TEXAS DEPARTMENT OF HEALTH — BUREAU OF VITAL STATISTICS

45-112, REV. 1/58

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE a. STATE <u>TX</u>	
b. CITY OR TOWN (if outside city limits, give precinct no.) <u>Dallas</u>		c. CITY OR TOWN (if outside city limits, give precinct no.) <u>Dallas</u>	
d. NAME OF (if not hospital, give street, hospital, OR INSTITUTION) <u>First Baptist</u>		d. STREET ADDRESS (if rural, give location) <u>1409</u>	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		e. IS RESIDENCE INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>John</u>		f. MARRIAGE STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Deceased	
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		16. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chokehold of Neighbor</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (d), stating the fatal type of cause last.		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			
20b. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____		20c. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.) <u>Home</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. CITY, TOWN, OR LOCATION <u>Dallas</u>	
20f. COUNTY <u>Dallas</u>		20g. STATE <u>TX</u>	
21. I hereby certify that I attended the decedent from birth, expired at _____ 19____ at _____ 21b. ADDRESS <u>5383 Mary Wess</u> 21c. NAME OF CHURCH OR CEMETERY <u>First Baptist</u> 21d. DATE <u>11-27-63</u> 21e. SIGNATURE <u>Mary Wess</u> 21f. DEGREE OF TITLE <u>Wife</u> 21g. DATE SIGNED <u>11-27-63</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		24. FUNERAL DIRECTOR'S SIGNATURE	
22b. LOCATION (City, town, or county)		24a. SIGNATURE	
25. REGISTRAR'S FILE NO.		26. DATE REC'D BY LOCAL REGISTRAR	
27. REGISTRAR'S SIGNATURE		28. REGISTRAR'S SIGNATURE	

Mary Wess 11-27-63

IF DECEASED SERVED IN U.S. ARMED FORCES, FILL OUT THE FOLLOWING:

Is the deceased reported to have been in such service?	
Name of organization in which service was rendered?	
Serial number of discharge papers or adjusted service certificate?	
Name of next of kin or of next friend?	
Post Office Address?	

IF DECEASED WAS MARRIED, FILL OUT THE FOLLOWING:

Name of husband or wife	Age in years
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IF DECEASED IS AN UNIDENTIFIED PERSON, FILL OUT THE FOLLOWING:

Color of Hair?	Color of Eyes?	Height?	Weight?
		ft. in.	
Deformities?	Tattoo Marks?		
Other marks of identification?			