

CERTIFICATE OF DEATH

STATE FILE NUMBER (For State Use only. Do not write in this box)

Area to be used by the Director or Registrar.

Area to be used by the Director or Registrar.

For use by Physician or Institution

Name of Decedent: Rollason, Ruth

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)

Ruth Eileen Rollason

2. SEX  
☐ Male  
☒ Female

3. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) (Specify Month)  
January 16, 2016

4. ACTUAL OR PRESUMED TIME OF DEATH  
1:20

5. AGE LAST BIRTHDAY  
92

6. UNDER 1 YEAR  
Mo. Days Hours Min.

7. DATE OF BIRTH (MM/DD/YYYY)  
03/26/1923

8. BIRTHPLACE (City, State or Foreign Country)  
Greenville, Maine

9. RESIDENCE (State)  
Connecticut

10. RESIDENCE (County)  
Middlesex

11. RESIDENCE (City or Town)  
Cromwell

12. RESIDENCE (Street and No.)  
52 Missionary Road

13. APT. NO.  
3312

14. ZIP CODE  
06416

15. EVER IN US ARMED FORCES?  
☐ Yes ☒ No

16. MARITAL STATUS AT TIME OF DEATH:  
☐ Married ☐ Married but separated ☒ Widowed  
☐ Divorced ☐ Never Married ☐ Unknown

17. SURVIVING SPOUSE'S NAME (Give full name prior to first marriage)  
N/A

18. FATHER'S NAME (First, Middle, Last)  
Fred Templeton

19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)  
Angie Stiles

20. INFORMANT'S NAME  
Mrs. Christie Rollason-Reese

21. INFORMANT'S RELATIONSHIP TO DECEDENT  
Daughter

22. MAILING ADDRESS (Street and Number, City, State, Zip Code)  
14 Hampden Place, Windsor, CT 06095

23. IF DEATH OCCURRED IN A HOSPITAL:  
☒ Inpatient ☐ ER/outpatient ☐ Dead on Arrival

24. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL:  
☐ Hospice Facility ☐ Nursing Home  
☐ Decedent's Home ☐ Other (specify)

25. FACILITY NAME (If not institution, give street & number)  
Hartford Hospital

26. CITY OR TOWN OF DEATH  
Hartford

ZIP CODE  
06102

27. COUNTY OF DEATH  
Hartford

28. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation  
☐ Entombment ☐ Removal from State  
☐ Other (specify)

29. DISPOSITION (Name of cemetery, crematory, other place)  
Brookside Crematory

30. LOCATION (city/town, state)  
Berlin, Connecticut

31. DATE (MM/DD/YYYY)  
01/19/2016

32. WAS BODY EMBALMED?  
If yes, Name of Embalmer ☐ Yes ☒ No

33. FUNERAL FACILITY - Name and Address (street, town, state, zip)  
Doolittle Funeral Home  
14 Old Church Street, Middletown, CT 06416

34. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER  
Nirish P. Chhabra

35. LICENSE NUMBER OF SIGNEE IN BOX 34  
2226

36. DATE PRONOUNCED DEAD (MM/DD/YYYY)  
01-16-2016

37. TIME PRONOUNCED  
1:20 PM

38. PRONOUNCER'S NAME AND DEGREE OR TITLE (Print)  
N/A

39. PRONOUNCER'S SIGNATURE  
N/A

40. DATE SIGNED  
N/A

41. WAS MEDICAL EXAMINER CONTACTED?  
☒ Yes ☐ No

42. WAS AN AUTOPSY PERFORMED?  
☐ Yes ☒ No

43. WERE THE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

44. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

APPROXIMATE INTERVAL ONSET TO DEATH:

IMMEDIATE CAUSE (Final disease or condition resulting in death)

(a) CARDIO RESPIRATORY ARREST

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) INTRA CEREBRAL HEMORRHAGE

(c)

(d)

45. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

46. IF FEMALE: ☒ Not pregnant within past year  
☐ Pregnant at time of death  
☐ Not pregnant, but pregnant within 42 days of death  
☐ Not pregnant, but pregnant 43 days to 1 year before death  
☐ Unknown if pregnant within the past year

47. DID TOBACCO USE CONTRIBUTE TO DEATH?  
☐ Yes ☐ Probably ☐ No ☒ Unknown

48. CERTIFIER (Check only one box) ☐ Certifying practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge death occurred due to the cause(s) and manner stated.  
☒ Pronouncing & Certifying Practitioner - I am the attending practitioner or a practitioner acting on behalf of the attending practitioner and to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated.

49. MAILING - CERTIFIER  
SVPRIYA TILGADI (Street)

Certifier Signature  
MD

Title of Certifier  
MD

THIS CERTIFICATE WAS RECEIVED FOR RECORD ON:  
JAN 19 2016

BY  
John V. Baygand 2016

REGISTRAR  
Title of Registrar  
MD

50. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.  
☐ 8<sup>th</sup> grade or less ☐ 9<sup>th</sup> - 12<sup>th</sup> grade, no diploma  
☒ High School Graduate/GED ☐ Some college credit, but no degree  
☐ Associate degree ☐ Bachelor's degree  
☐ Master's degree ☐ Doctorate or Professional degree  
☐ Unknown ☐ Not available

51. DECEDENT OF HISPANIC ORIGIN?  
☒ No, Not Spanish/Hispanic/Latino  
☐ Yes, Mexican, Mexican American, Chicano  
☐ Yes, Puerto Rican  
☐ Yes, Cuban  
☐ Yes, other Spanish/Hispanic/Latino (specify)

52. DECEDENT'S RACE  
☒ White ☐ Black or African American ☐ Asian Indian  
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)  
☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese  
☐ Other Asian (specify) ☐ Native Hawaiian ☐ Guamanian or Chamorro  
☐ Samoan ☐ Other Pacific Islander (specify)  
☐ Other (specify)

53. DECEDENT'S USUAL OCCUPATION  
secretary

54. KIND OF BUSINESS/INDUSTRY  
Board of Education

55. SOCIAL SECURITY NUMBER  
048-12-9430

I CERTIFY THAT THIS IS A TRUE COPY OF THE CERTIFICATE AS RECORDED IN THIS OFFICE:

ATTESTED: John V. Baygand 2016

REGISTRAR OF VITAL STATISTICS

DATED: January 19, 2016

CITY OF "HARTFORD CONNECTICUT"

NOT VALID WITHOUT SEAL OF THE "HARTFORD HEALTH DEPARTMENT"

ADMINISTRATIVE USES