

**STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CERTIFICATE OF DEATH**

STATE FILE NUMBER

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MANENT
ACK INK
FOR
DUCTIONS
SEE
HER SIDE
HANDBOOK

3a.

9b.

9d.

Pronouncing
Physician
Only →
See ↑
Definition
On Other
Side

12a.

12b.

13a.

13b.

13c.

30e.

1. DECEDENT'S NAME First Middle Last Rosa Lee Harrison Taylor		SEX Female	DATE OF DEATH (Month, Day, Year) Jan. 16, 1998
SOCIAL SECURITY NUMBER 4 251-60-1989	AGE - Last Birthday (Years) 5a. 97 5b. 97	DATE OF BIRTH (Mo., Day, Year) Mar. 23, 1900	BIRTHPLACE (City, and State or Foreign Country) Fairfield County, SC
6. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) No		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
7. FACILITY NAME (If not institution, give street and number) Baptist Medical Center		8. CITY, TOWN, OR LOCATION OF DEATH Columbia	9. COUNTY OF DEATH Richland
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed		11. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Janitorial	
12. KIND OF BUSINESS/INDUSTRY Hospital		13. INSIDE CITY LIMITS? (Yes or No) no	
13a. RESIDENCE - STATE SC	13b. COUNTY Richland	13c. CITY, TOWN, OR LOCATION Columbia	13d. STREET AND NUMBER 212 Everett Street
13e. ZIP CODE 29223	14. 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 (Specify)		15. RACE - American Indian, Black, White, etc. (Specify) Black
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-) 8th 0	17. FATHER'S NAME First Middle Last Henry Harrison		
18. MOTHER'S NAME First Middle Francis Graves		19. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Clinton St., Columbia, SC 29223	
20. INFORMANT'S NAME (Type/Print) Thelma Martin		21. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Old Rehoboth Bapt Church Cem.	
22. 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)		23. LOCATION - (City or Town, State) Blythewood, SC	
24. FUNERAL DIRECTOR OR PERSON ACTING AS SUCH (Signature) E. P. Palmer		25. FUNERAL DIR. LICENSE NO. 872	26. NAME AND ADDRESS OF FACILITY Palmer Memorial Chapel 1200 Fontaine Place Columbia, South Carolina 29223
27. EMBALMER (Signature) A. A. Dicks		28. EMBALMER LICENSE NO. 1594	29. LICENSE NUMBER 95
30. Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.		31. Signature and Title	32. DATE SIGNED (Month, Day, Year)
33. TIME OF DEATH 7:03 A.M.		34. DATE PRONOUNCED DEAD (Month, Day, Year) No	
35. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) No		36. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
37. PART I. Enter the disease, injuries, or complications that caused the 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.			
38. IMMEDIATE CAUSE (Final disease or condition resulting in death) Pneumonia			
39. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerosis secondary to #1			
40. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST			
41. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
42. MA MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		43. DATE OF INJURY (Month, Day, Year) 30e.	44. TIME OF INJURY 30b.
45. INJURY AT WORK? (Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		46. DESCRIBE HOW INJURY OCCURRED 30d.	
47. PLACE OF INJURY - (Home, Farm, Street, Factory, Office, etc.) (Specify) 30c.		48. LOCATION (Street and Number or Rural Route Number, City or Town, State) 30f.	
49. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death) <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death)		50. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER 32.	
51. SIGNATURE AND TITLE OF CERTIFIER To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 31.		52. LICENSE NUMBER 33b. 14800	53. DATE SIGNED (Month, Day, Year) 33c. 1/20/98
54. NAME AND ADDRESS OF PERSON WHO SIGNED IN 33a. (Type/Print) Peggy Toliver-Dingle, MD 1301 Taylor St. Suite 2-H, Columbia, SC			
55. REGISTRAR'S SIGNATURE 35.		56. DATE SIGNED (Month, Day, Year) January 20, 1998	

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