

CERTIFICATION OF VITAL RECORD

**DEPARTMENT OF STATE HEALTH SERVICES
VITAL STATISTICS UNIT**

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS
AUG 09 2012
STATE OF TEXAS **CERTIFICATE OF DEATH** **STATE FILE NUMBER 142-12-100153**

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS UNIT

1. LEGAL NAME OF DECEASED (Include AKA's, if any) (First, Middle, Last) JONATHAN E. BEITCH				2. DATE OF DEATH - ACTUAL OR PRESUMED (mm-dd-yyyy) AUGUST 5, 2012	
3. SEX MALE	4. DATE OF BIRTH (mm-dd-yyyy) FEBRUARY 1, 1965	5. AGE - Last Birthday (Years) 47	IF UNDER 1 YR Mo Days	IF UNDER 1 DAY Hours Min	6. BIRTH-PLACE (City & State or Foreign Country) KOREA
7. SOCIAL SECURITY NUMBER 045-70-1397			8. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Unknown		
10a. RESIDENCE STREET ADDRESS 3266 TRES LOGOS LANE			10b. APT NO		10c. CITY OR TOWN DALLAS
10d. COUNTY DALLAS		10e. STATE TEXAS		10f. ZIP CODE 75228	10g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11. FATHER'S NAME IRWIN BEITCH			12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE BARBARA ROSE		
13. PLACE OF DEATH (CHECK ONLY ONE) IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)					
14. COUNTY OF DEATH DALLAS		15. CITY/TOWN, ZIP (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO) DALLAS, 75218		16. FACILITY NAME (If not institution, give street address) DOCTORS HOSPITAL - DALLAS	
17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED SANDRA PALOMINO - SPOUSE			18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code) 3266 TRES LOGOS LANE, DALLAS, TX 75228		
19. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from state <input type="checkbox"/> Other (Specify)		20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH WENDELL JACKSON COX, BY ELECTRONIC SIGNATURE - 113127		21. <input checked="" type="checkbox"/> Unknown Section _____ Block _____ Lot _____ Space _____	
22. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) REST HAVEN CREMATORY		23. LOCATION (City/town, and State) ROCKWALL, TX		25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) 8499 GREENVILLE AVE. SUITE 107, DALLAS, TX 75231	
24. NAME OF FUNERAL FACILITY LOCALCREMATION.COM		26. CERTIFIER (Check only one) <input checked="" type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/Justice of the Peace - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
27. SIGNATURE OF CERTIFIER J K TOWNSEND-PARCHMAN, BY ELECTRONIC SIGNATURE		28. DATE CERTIFIED (mm-dd-yyyy) AUGUST 9, 2012	29. LICENSE NUMBER H1421	30. TIME OF DEATH (Actual or presumed) 11:45 AM	
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) J K TOWNSEND-PARCHMAN 2355 N. STEMMONS FWY, DALLAS, TX 75207				32. TITLE OF CERTIFIER MD	
33. PART 1. 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 EACH.					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. PENDING		Approximate interval Onset to death UNKNOWN	
Due to (or as a consequence of):		b.			
Due to (or as a consequence of):		c.			
Due to (or as a consequence of):		d.			
PART 2. ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1.				34. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
				35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
36. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to one year before death <input type="checkbox"/> Unknown if pregnant within the past year	
39. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		40a. DATE OF INJURY (mm-dd-yyyy)			
40b. TIME OF INJURY		40c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		40d. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)	
40e. LOCATION (Street and Number, City, State, Zip Code)				40f. COUNTY OF INJURY	
41. DESCRIBE HOW INJURY OCCURRED					
42a. REGISTRAR FILE NO 0205932		42b. DATE RECEIVED BY LOCAL REGISTRAR AUGUST 9, 2012		42c. REGISTRAR REGISTRAR - CITY OF DALLAS, ELECTRONICALLY FILED	
EDR NUMBER 000001179884					

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine up to \$10,000. (Health and Safety Code, Sec. 195, 1989)



VS-112 REV 1/2006

JHE

This is a true and correct reproduction of the original record as recorded in this office. Issued under authority of Section 191.051, Health and Safety Code.

ISSUED AUG 10 2012

WARNING: THIS DOCUMENT HAS A DARK BLUE BORDER AND A COLORED BACKGROUND

Geraldine F. Harris
GERALDINE F. HARRIS
STATE REGISTRAR

