

1. NAME: FIRST MIDDLE LAST EILEEN M. FRANCLEMONT 2. SEX: MALE FEMALE 3A. DATE OF DEATH: MONTH DAY YEAR 3B. HOUR: 02 09 2011 2:10 P. 4A. PLACE OF DEATH: HOSPITAL DOA ER HOSPITAL OUTPATIENT HOSPITAL INPATIENT NURSING HOME PRIVATE RESIDENCE HOSPICE FACILITY OTHER (Specify): 4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR 4C. NAME OF FACILITY: (If not facility, give address) 4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN 4E. COUNTY OF DEATH: 4F. MEDICAL RECORD NO. 4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) 5. DATE OF BIRTH: MONTH DAY YEAR 6A. AGE IN YEARS: 6B. IF UNDER 1 YEAR ENTER: months days 6C. IF UNDER 1 DAY ENTER: hours minutes 7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) 7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH: 8. SERVED IN U.S. ARMED FORCES? (Specify years) 9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino 10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be: 11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death: 12. SOCIAL SECURITY NUMBER: 13. MARITAL STATUS: NEVER MARRIED MARRIED WIDOWED DIVORCED SEPARATED 14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name. 15A. USUAL OCCUPATION: (Do not enter retired) 15B. KIND OF BUSINESS OR INDUSTRY: 15C. NAME AND LOCALITY OF COMPANY OR FIRM: 16A. RESIDENCE: (State or Country if not USA) 16B. County or Region/Province if not USA: 16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN 16D. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES NO IF NO, SPECIFY TOWN: 16E. ZIP CODE: 16F. STREET AND NUMBER OF RESIDENCE: 17. NAME OF FATHER: FIRST MI LAST 18. MAIDEN NAME OF MOTHER: FIRST MI LAST 19A. NAME OF INFORMANT: 19B. MAILING ADDRESS: (include zip code) 20A. 1 BURIAL 2 CREMATION 3 REMOVAL 4 HOLD DAY 5 DONATION YEAR 20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: 20C. LOCATION: (City or town and state) 21A. NAME AND ADDRESS OF FUNERAL HOME: 21B. REGISTRATION NUMBER: 22A. NAME OF FUNERAL DIRECTOR: 22B. SIGNATURE OF FUNERAL DIRECTOR: 22C. REGISTRATION NUMBER: 23A. SIGNATURE OF REGISTRAR: 23B. DATE FILED: MONTH DAY YEAR 23C. BURIAL OR REMOVAL PERMIT ISSUED BY: 23D. DATE ISSUED: MONTH DAY YEAR 25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated. Certifier's Name: License No.: Signature: Month Day Year 25B. If certifier is not a physician, enter Coroner's Physician's name & title: License No.: Signature: Month Day Year 25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address: 26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year 26B. Deceased last seen alive by attending physician: Month Day Year 26C. Pronounced Dead by M.E. or Coroner: OR Month Day Year AT Time 27. MANNER OF DEATH: NATURAL CAUSE ACCIDENT HOMICIDE SUICIDE UNDETERMINED CIRCUMSTANCES PENDING INVESTIGATION 28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 29A. AUTOPSY? 29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 29C. INJURY AT WORK? 30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)) PART I. IMMEDIATE CAUSE: (A) (B) (C) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): 31A. IF INJURY, DATE: MONTH DAY YEAR 31B. INJURY LOCALITY: (City or town and county and state) 31C. DESCRIBE HOW INJURY OCCURRED: 31D. PLACE OF INJURY: 31E. INJURY AT WORK? 31F. IF TRANSPORTATION INJURY, SPECIFY: 32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? 33A. IF FEMALE: 33B. DATE OF DELIVERY: MONTH DAY YEAR

For use by physician or institution:

NAME OF DECEDENT: DATE OF DEATH: ANY PM