NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
N.C. VITAL RECORDS

CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. _____ LOCAL NO. _____ COUNTY OF DEATH Polk STATE FILE NO. _____

DECEDENT

TYPE/PRINT IN PERMANENT BLACK, BLUE-BLACK OR BLUE INK

DECEDENT'S LEGAL NAME

1a. FIRST	1b. MIDDLE	1c. LAST	1d. SUFFIX	1e. LAST NAME PRIOR TO FIRST MARRIAGE
Hertha	Emma	Flack		Eisenmenger
aka	aka	aka		

2. SEX	3a. AGE-LAST BIRTHDAY (Yrs)	3b. UNDER 1 YEAR Months	Days	3c. UNDER 1 DAY Hours	Minutes	4. DATE OF BIRTH (Month/Day/Year)	5. BIRTHPLACE (County/State or Foreign Country)	6. DATE OF DEATH (Month/Day/Year)
F	102					October 10, 1916	Cuyahoga, OH	March 23, 2019

PLACE OF DEATH (Check only one)

7a. IF DEATH OCCURRED IN A HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA

7b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL ☐ Hospice facility ☐ Nursing home/Long term care facility ☑ Decedent's home ☐ Other (Specify) _____

7c. FACILITY NAME (If not institution, give street and number)	7d. CITY OR TOWN	7e. COUNTY OF DEATH
615 Laurel Lake Drive, Apt. A145	Columbus	Polk

8. MARITAL STATUS	9. SURVIVING SPOUSE (Give name prior to first marriage)	10a. DECEDENT'S USUAL OCCUPATION (Do not use retired)	10b. KIND OF BUSINESS/INDUSTRY
☐ Married ☐ Married, but separated ☑ Widowed ☐ Divorced ☐ Never married ☐ Unknown	None	Homemaker	Own Home

11. SOCIAL SECURITY NUMBER	12a. RESIDENCE–STATE OR FOREIGN COUNTRY	12b. COUNTY	12c. CITY OR TOWN
065-40-7115	North Carolina	Polk	Columbus

12d. STREET AND NUMBER	12e. INSIDE CITY LIMITS	12f. ZIP CODE	13. WAS DECEDENT EVER IN U.S. ARMED FORCES?
615 Laurel Lake Drive, Apt. A145	☐ Yes ☑ No	28722	☐ Yes ☑ No

NAME OF DECEDENT (For use by Physician, Institution or Medical Examiner): Hertha Emma Flack

14. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death)
- ☐ 8th grade or less
- ☐ 9th–12th grade; no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☑ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

15. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino)
- ☑ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify) _____

16. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
- ☑ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese
- ☐ Other Asian (Specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) _____
- ☐ Other (Specify) _____

PARENTS

17. FATHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage)	18. MOTHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage)
Hugo Emil Eisenmenger	Charlotte Sonya Escherich

19a. INFORMANT'S NAME	19b. RELATIONSHIP TO DECEDENT	19c. MAILING ADDRESS (Street and Number, City, State, Zip Code)
James M. Flack II	Son	P.O. Box 126, Sebastopol, CA 95473

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)	20c. LOCATION (City or Town and State)
☐ Burial ☑ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify) _____	McFarland Crematory	Tryon, NC

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER	21c. NAME OF EMBALMER	21d. LICENSE NUMBER
[signature]	2552 NCFS	Not Embalmed	

22. NAME AND ADDRESS OF FUNERAL HOME: McFarland Funeral Chapel, 54 McFarland Drive, Tryon, NC 28782

MEDICAL CERTIFICATION

23. 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 on lines b, c and/or d. Enter only one cause on a line. DO NOT ABBREVIATE.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chronic heart failure	
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. Hypertension Due to (or as a consequence of)	
	c. Due to (or as a consequence of)	
	d. Due to (or as a consequence of)	

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

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?
☐ Yes ☑ No	☐ Yes ☐ No

25. MANNER OF DEATH	26a. WAS CASE REFERRED TO MEDICAL EXAMINER?	26b. IF YES	27. TIME OF DEATH (Approximate)	28. DID TOBACCO USE CONTRIBUTE TO DEATH?	29. IF FEMALE:
☑ Natural ☐ Homicide ☐ Accident ☐ Pending ☐ Suicide ☐ Cannot be determined	☐ Yes ☑ No	☐ Declined by Medical Examiner	12:44 AM	☐ Yes ☐ Probably ☑ No ☐ Unknown	☐ Pregnant at time of death ☑ Not pregnant within past year ☐ 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

BURIAL/CREMATION PERMIT — Medical Examiner: Authorization for Disposition/Transportation: After the medical examiner completes and signs this burial transit permit/cremation authorization, it constitutes authority for burial, cremation, transportation or removal from the state. A copy of this form serves as a Burial/Cremation Permit.

MEDICAL EXAMINER ONLY

30. DATE PRONOUNCED (Month/Day/Year)	31a. DATE OF INJURY (Month/Day/Year)	31b. TIME OF INJURY	31c. INJURY AT WORK?	31d. PLACE OF INJURY–at home, farm, street, factory, office, building, etc.	31e. IF TRANSPORTATION INJURY SPECIFY:
			☐ Yes ☐ No		☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

31f. DESCRIBE HOW INJURY OCCURRED	31g. LOCATION OF INJURY (Street/Number/City/State)

CERTIFIER

32. CERTIFIER (Check only one)
- ☑ Certifying physician/nurse practitioner/physician assistant – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
- ☐ Medical Examiner – 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.

33a. SIGNATURE AND TITLE OF CERTIFIER	33b. LICENSE NUMBER	33c. DATE SIGNED (Month/Day/Year)
Julie Thorn ABNP-C	500944	3/26/2019

33d. NAME AND ADDRESS OF CERTIFIER (Print legibly): Julie Thorn ABNP-C 314 Hudlow Rd. Forest City, NC 28043

REGISTRAR

34. FOR LOCAL REGISTRAR (Name)	35. DATE FILED (Month/Day/Year)	36. DATE REGISTERED BY STATE

DATE CORRECTED (Mo/Day/Yr)	ITEM(S) CORRECTED:
DATE AMENDED (Mo/Day/Yr)	ITEM(S) AMENDED:

Substitute For DHHS 1672 (REVISED 11/2017) N.C. VITAL RECORDS