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STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER
1324205

TYPE/PRINT IN PERMANENT BLACK INK

NAME OF DECEDENT FOR USE BY PHYSICIAN OR INSTITUTION

DECEDENT

1 DECEDENT'S NAME (First, Middle, Last)			2 SEX	3 DATE OF DEATH (Month, Day, Year)
JAMES	JUSTIN	PERRY	MALE	OCTOBER 20, 1997

4a AGE - Last Birthday (Years)	4b. UNDER 1 YEAR MONTHS	4b. UNDER 1 YEAR DAYS	4c. UNDER 1 DAY HOURS	4c. UNDER 1 DAY MINUTES	5 DATE OF BIRTH (Month, Day, Year)	6 COUNTY OF DEATH
92					JULY 31, 1905	WAYNE

7a LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c.) HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)	7b IF HOSP OR INST Inpatient, Op /Emer Room, DOA (Specify)	7c. CITY, VILLAGE, OR TOWNSHIP OF DEATH
RIVERGATE TERRACE	INPATIENT	RIVERVIEW

8 SOCIAL SECURITY NUMBER	9a. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	9b KIND OF BUSINESS OR INDUSTRY
364-10-1603	YARDMASTER	UTILITY

10a CURRENT RESIDENCE - STATE	10b COUNTY	10c. LOCALITY (Check one box and specify)	10d STREET AND NUMBER
MICHIGAN	WAYNE	[X] INSIDE CITY OR VILLAGE OF [ ] TWP. OF WYANDOTTE	1405 12th. ST.

10e ZIP CODE	11 BIRTHPLACE (City and State or Foreign Country)	12. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	13 SURVIVING SPOUSE (If wife, give name before first married)	14 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)
48192	WYANDOTTE MICHIGAN	MARRIED	SOPHIE PIATKOWSKI	NO

15. ANCESTRY - Mexican, Puerto Rican, Cuban, Central or South American, Chicano, other Hispanic, Afro-American, Arab, English, French, Finnish, etc. (Specify below)	16. RACE - American Indian, Black, White, etc If Asian, give nationality i.e., Chinese, Filipino, Asian Indian, etc (Specify below)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
		Elementary/Secondary (0-12)	College (1-4 or 5+)
FRENCH	WHITE	9	

PARENTS

18 FATHER'S NAME (First, Middle, Last)			19 MOTHER'S NAME (First, Middle, Surname before first married)	
JAMES	ALMOND	PERRY	JULIA	GONIA (AKA GONYEA)

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Village, State, ZIP Code)
SOPHIE PERRY	1405 12th. ST. WYANDOTTE, MICHIGAN 48192

DISPOSITION

21. METHOD OF DISPOSITION - Burial, Cremation, Removal, Donation, Other (specify)	22a PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place)	22b. LOCATION - City or Village, State
BURIAL	HOLY SEPULCHRE CEMETERY	SOUTHFIELD, MICHIGAN

23. SIGNATURE OF FUNERAL SERVICE LICENSEE	24 LICENSE NUMBER (of Licensee)	25 NAME AND ADDRESS OF FACILITY
▶ Gary A Kwiat	5248	CZOPEK FUNERAL DIRECTORS 2157 OAK ST. WYANDOTTE, MICHIGAN 48192

CAUSE OF DEATH

26 PART I Enter the diseases, 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

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition → resulting in death)	a ACUTE MYOCARDIAL INFARCTION	MINUTE
	DUE TO (OR AS A CONSEQUENCE OF)	
Sequentially list conditions, IF ANY, leading to immediate cause Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b ASHD	YEARS
	DUE TO (OR AS A CONSEQUENCE OF)	
	c	
	DUE TO (OR AS A CONSEQUENCE OF)	
	d	

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

SDAT; PROTEIN CAL MALNUTRITION

27a WAS AN AUTOPSY PERFORMED? (Yes or No)	27b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
NO	

CERTIFIER

28 ACTUAL PLACE OF DEATH (Home, Nursing Home, Hospital, Ambulance) (Specify)	29 WAS CASE REFERRED TO MEDICAL EXAMINER? (Specify Yes or No)
NURSING HOME	NO

CERTIFYING PHYSICIAN

30a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated (Signature and Title) ▶ [signature]

30b DATE SIGNED (Mo., Day, Yr.)	30c. TIME OF DEATH
OCTOBER 20, 1997	4:50 A M

30d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

MEDICAL EXAMINER

31a (Check one only) [ ] The case reviewed and determined not to be a medical examiner's case [ ] On the basis of examination and of investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner stated

(Signature and Title) ▶

31b DATE SIGNED (Mo., Day, Yr.)	31c CASE NUMBER

31d PRONOUNCED DEAD (Mo., Day, Yr.)	31e TIME OF DEATH
ON	M

MEDICAL EXAMINER

32a NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type or Print)	32b LICENSE NUMBER
DAVID M. MILLER D.O. 17800 NEWBURGH LIVONIA	005463

33a ACC SUICIDE, HOM., NATURAL OR PENDING INVEST (Specify)	33b DATE OF INJURY (Mo., Day, Yr.)	33c. TIME OF INJURY M	33d DESCRIBE HOW INJURY OCCURRED

33e INJURY AT WORK (Specify Yes or No)	33f PLACE OF INJURY - At home, farm, street, factory, office building, etc (Specify)	33g LOCATION - Street or R F D No City, Village or Twp State

34a REGISTRAR'S SIGNATURE	34b DATE FILED (Month, Day, Year)
▶ Leslie D. Beswick	OCTOBER 22, 1997

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