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APR 15 1991

Metropolitan Government of Nashville and Davidson County

Bill Boner, Mayor

METROPOLITAN HEALTH DEPARTMENT
311 23rd AVENUE, NORTH
NASHVILLE, TENNESSEE 37203
(615) 327-9313

This is to certify that this is a true and correct copy of the record filed with the Tennessee Department of Public Health, Vital Records, by the Metropolitan Health Department of Nashville and Davidson County.

This is valid only when the seal of the Metropolitan Health Department of Nashville and Davidson County is affixed.

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT

CERTIFICATE OF DEATH

STATE FILE NUMBER 9101696

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

DECEDENT

1 DECEDENT'S NAME (First, Middle, Last): Hazel Morrison Sealy

2 SEX: M

3 DATE OF DEATH (Month, Day, Year): April 4, 1991

4 SOCIAL SECURITY NUMBER (of Deceased): [redacted]-3678

5a AGE – LAST BIRTHDAY (Years): 88

5b UNDER 1 YEAR: MOS / DAYS

5c UNDER 1 DAY: HOURS / MIN

6 DATE OF BIRTH (Month, Day, Year): 9/17/02

7 BIRTHPLACE (City and State or Foreign Country): Columbia, TN

8 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] Yes 2 [X] No

9a PLACE OF DEATH (Check only one): HOSPITAL 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

9b FACILITY NAME (If not institution, give street and number): Nashville Memorial Hospital

9c CITY, TOWN OR LOCATION OF DEATH: Madison

9d COUNTY OF DEATH: Davidson

5

10 MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Lillian Street

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Sheet Metal Worker

12b KIND OF BUSINESS/INDUSTRY: Dillham Sheet Metal

13a RESIDENCE – STATE: Tennessee

13b COUNTY: Davidson

13c CITY, TOWN OR LOCATION: Nashville

13d STREET AND NUMBER OR RURAL LOCATION: 3820 Katherine St.

CENSUS TRACT

13e INSIDE CITY LIMITS? 1 [X] Yes 2 [ ] No

13f ZIP CODE: 37216

14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No – If yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] Yes 0 [X] No

Specify, if yes:

15 RACE – American Indian, Black, White, etc. (Specify): White

16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)

NAME OF DECEDENT: For use by physician or institution

PARENTS

17 FATHER'S NAME (First, Middle, Last): W. J. Sealy

18 MOTHER'S NAME (First, Middle, Maiden Surname): Ida (Unknown)

INFORMANT

19a INFORMANT'S NAME (Type/Print): Ronald Sealy

19b RELATIONSHIP TO DECEASED: Son

19c MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 Luna Lane, Hendersonville, TN 37075

DISPOSITION

20a METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Spring Hill Cemetery

20c LOCATION – City or Town, State: Nashville, TN

21a SIGNATURE OF FUNERAL DIRECTOR: ▶ Robb Robinson

21b LICENSE NUMBER OF FUNERAL DIRECTOR: 346

21c SIGNATURE OF EMBALMER: ▶ Ron Reed

21d LICENSE NUMBER OF EMBALMER: 3964

22a NAME AND ADDRESS OF FUNERAL HOME: Phillips-Robinson Co., 2707 Gallatin Rd., Nashville, TN 37216

22b LICENSE NUMBER OF FUNERAL HOME: 331

REGISTRAR

23 REGISTRAR'S SIGNATURE: ▶ Mary C. Pentecost

24 DATE FILED (Month, Day, Year): April 15, 1991

CERTIFIER

PHYSICIAN OR MEDICAL EXAMINER EXECUTING CERTIFICATE MUST COMPLETE AND SIGN MEDICAL CERTIFICATION WITHIN 48 HOURS

25a PHYSICIAN – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

1 [ ] SIGNATURE AND TITLE OF PHYSICIAN: ▶ James L Ward

25b LICENSE NUMBER:

25c DATE SIGNED (Month, Day, Year): 4/8/91

26a MEDICAL EXAMINER – On the basis of examination and/or investigation, in my opinion, death occurred at the time, and place, and due to the cause(s) and manner as stated

2 [ ] SIGNATURE AND TITLE OF MEDICAL EXAMINER: ▶

26b LICENSE NUMBER:

26c DATE SIGNED (Month, Day, Year):

27 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR MEDICAL EXAMINER) (Type/Print): Dr. James Ward 610 W. Due West Ave., Madison, TN 37115

CAUSE OF DEATH

28 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. Cardiorespiratory Arrest — minutes

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. Myocardial Infarction — hours

DUE TO (OR AS A CONSEQUENCE OF)

c. Atherosclerotic Cardiovascular Disease — years

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.

28a WAS AN AUTOPSY PERFORMED? 1 [ ] Yes 2 [ ] No

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] Yes 2 [ ] No

30 MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be Determined

31a DATE OF INJURY (Month, Day, Year)

31b TIME OF INJURY: M

31c INJURY AT WORK? 1 [ ] Yes 2 [ ] No

31d DESCRIBE HOW INJURY OCCURRED

31e PLACE OF INJURY – At home, farm, street, factory, office building, etc. (Specify)

31f LOCATION (Street and Number or Rural Route Number, City or Town, State)

BIRTH NO. _____

PH-1659
REV 1/89

202-06-002 (Rev. 10/89)

RECORDER'S NOTE
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IDENTIF. REFERENCE

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FELDMAN & [illegible]
DAVIDSON COUNTY, TN.

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