ILLINOIS DEPARTMENT OF PUBLIC HEALTH Division of Vital Records Electronic Death Registration System (EDRS)

WORK COPY

Fax Cover Sheet

RE: TRACKING NO: 692273		Date & Time Sent:
		May21, 2008 8:19 AM
Pages: 2		
TO CERTIFYING PHYSICIAN:	S. L. Marr, MD	
OFFICE PHONE NO:	217-555-3412	
FROM FUNERAL HOME:	Derricks FH	
OFFICE PHONE NO:	217-555-8759	
FAX NO:	217-555-8758	

Thank you for participating in the Illinois EDRS Fax Attestation Process. Please follow the steps below to complete the cause of death certification:

- Attached is a WORK COPY of the medical portion of the death record for your patient named in item 1.
- Verify the decedent's Name, Date and Place of death (items 1, 3, 4, 7a, 7b, 7c).
- Starting with item 24, complete the medical portion of the record.
- Fax the completed WORK COPY to the Funeral Home at 1-217-557-7104
- •The funeral director will input the information provided from the WORK COPY into the EDRS
- •The system will send you a completed ATTESTATION COPY for review and signature.
- •If there are any questions or this was faxed to you in error, contact the funeral home listed on this cover sheet.

TRACKING NO: 692273 ILLINOIS CERTIFICATE OF DEATH								
DECEDENT'S LEGAL NAME (Include A KRIS K KROSS	KAs if any) (First, Middle	, Last)			2. SEX		TE OF DEATH	(Month/Day/Year) (Spell Month)
4. COUNTY OF DEATH	5a. AGE AT LAST BIRT	THDAY (Years) 5b. U	INDER 1 YEAR	5c. UNDER				nth/Day/Year)
ALEXANDER	98	Mor	nths Days	Hours	Minutes	FEE	BRUARY 2	l, 1910
7a. CITY OR TOWN			7b. HOSPITAL OF	OTHER INSTITUTI	ION NAME	(If not in either, giv	e street and nu	mber)
EAST CAPE GIRARDEAU		7c. PLACE OF DI	EATH (Check only	one: see instructio	ons)			
IF DEATH OCCURRED IN A HOSPITAL	patient 🔲 Dead on Arriv	l <u> </u>	CCURRED SOMEW	HERE OTHER THAN		L Decedent's Home	X Other (Sp	ecify): SCENE
WORKCOPY								
Please com	nlete th	e Cau	se of l	Death	Sec	rtion	helc	1 \ A /
	•							/ V V
starting with	i item 2	4. vvn	en coi	mplete	ea, t	ax to	the	
Funeral Dire	ector at	(217)	557-7	128.				
21a. FUNERAL HOME NAME DERRICKS FH		REET AND NUMBER 2 SOUTH MAIN		CITY OR	TOWN		STATE ILLINOIS	ZIP 6295 7
21b. FUNERAL DIRECTOR'S SIGNATURE RICK R RORY		2 3 3 3 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	'			RAL DIRECTOR'		CENSE NUMBER
22. LOCAL REGISTRAR'S SIGNATURE JAMES J JOKER							CAL REGISTR	AR (Month/Day/Year)
CAUSE OF DEATH (See Instruct				O NIOT III II II		. P		APPROXIMATE INTERVAL
 PART I. Enter the chain of events - di respiratory arrest or ventricular fibrillation Dementia Complex, indicate in Part I or 	n without showing etiolog	y. If the decedent had	d a dementia related	disease, Parkinson	n's Disease, or	r Parkinson	est, BE	TWEEN ONSET AND DEATH
IMMEDIATE CAUSE (final disease or condition resulting in death)	l		Due to (or as a cor	seguence of):			-	
Sequentially list conditions, If any, leading to the cause listed on line a. b.								
(disease or injury that initiated the								
	contributing to death		Due to (or as a cor e underlying cause o			25. WAS AN A	AUTOPSY PER	RFORMED? Tyes No
26. WERE AUTOPSY FINDINGS USED TO							NGS USED TO	
27. DID TOBACCO USE 28. IF FEMALE: 29. MAN					_	NNER OF DEATH ral Suicide Could not be determined		
Yes Probably Not	oregnant, but pregnant within oregnant, but pregnant 43 da	42 days of death	Pregnant withi	n one year of death bu gnant within the past 1		=	Homicide	Pending Investigation
30. DATE OF INJURY (Month/Day/Year)	31. TIME OF		2. PLACE OF INJU			on site; restaurant;	wooded area)	33. INJURY AT WORK?
34. LOCATION OF INJURY Street and N	umber	Apartment Nun	mber City	or Town		State		ZIP Code
35. DESCRIBE HOW INJURY OCCURRED:					☐ Driver		Pedestrian	ECIFY:
37. I (DID) (DID NOT) ATTEND THE DECEA	SED (Month/Day/Year)	38. WAS MEDICAL E	EXAMINER OR	39. DAT	Passe TE PRONOUN		Other (Specify) y/Year) 40	. TIME OF DEATH
AND LAST SAW HIM/HER ALIVE ON		CORONER CONTA	ACTED? Yes	X No			0:	2:00 A.M. X P.M.
41. CERTIFIER (Check only one): Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.								
Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated. Medical Examiner/Coroner - 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.								
42. NAME, ADDRESS AND ZIP CODE OF P				arred at the time, da	ate and place,	and due to the		CIAN'S LICENSE NUMBER
MARR, SPLD 44. TITLE OF CERTIFIER	45.	DATE CERTIFIED (N	Month/Day/Year)	<u> </u>				
PHYSICIAN IN CHARGE		(P		PHYSICIA	AN'S SIG	NATURE	NOT NEE	EDED AT THIS TIME
0001078909		46. SIGNATURE OF	- CERTIFIER					

Page 2 of 2

Wed May 21 08:20:43 2008 From DPH-DEV-TEST 692273 ILLINOIS CERTIFICATE OF DEATH TRACKING NO: 3. DATE OF DEATH (Month/DayYear) (Spel Month) 2. SEX 1 DECEDENT'S LEGAL NAME (Include AKAs if any) First, Middle, Lest) MALE MAY 21, 2008 KRIS K KROSS 6. DATE OF BIRTH (Month/Day/Year) 65. UNDER 1 DAY 4. COUNTY OF DEATH 5a. AGE AT LAST BIRTHDAY (Years) 55 UNDER 1 YEAR Minutos **FEBRUARY 2, 1910 ALEXANDER** 7b. HOSP TAL OR OTHER INSTITUTION NAME (if not in either, give street and rumber) 76 CITY OR TOWN EAST CAPE GIRARDEAU 7o. PLACE OF DEATH (Check only one: see instructions) IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL IF DEATH OCCURRED IN A HOSPITAL ☐ Mospice Facility ☐ Burraing Home/Long-term care racility ☐ Describent's Home ☒ Other (Bipacity): SCENE ☐ npztient ☐ Energency Rnom/Quitpatient ☐ Dead on Arrival WORKCOPY Please complete the Cause of Death Section below starting with Item 24. When completed, fax to the Funeral Director at (217) 557-7128. CITY OR TOWN STREET AND NUMBER 21a, FUNERAL HOME 62957 **DERRICKS FH** 222 SOUTH MAIN EAST CAPE GIRARDE/ ILLINOIS 21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 215 FUNERAL DIRECTOR'S SIGNATURE 034010450 RICK R RORY 23 DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) 22. LOCAL REGISTRAR'S SIGNATURE JAMES J JOKER CAUSE OF DEATH (See instructions and examples) APPROXIMATE INTERVAL 24 PART I Enter the chain of events - diseases (n) mas or complications - that directly caused the death DO NOT enter terminal events such as dardied extest, BETWEEN ONSET AND DRATH respiratory errest or ventricular fibrillation without showing obology. If the decodent had a dementia related disease, Perkinson's Disease, or Perkinson Dementia Complex, indicate in Part I or Part II DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary. IMMEDIATE CAUSE (final disease or condition resulting in sleath) Sequentially list conditions, if any, leading to the cause listed on line a Enter the UNDERLYING CAUSE (disease or injury that initiated the evente regulting in death) LAST Due to (or as a consequence of): PART II. Entor other significant conditions contribution to death but not resulting in the underlying cause given in PART I 26 WAS AN AUTOPSY PERFORMED? □ Yes □ No. 26 WERE AUTOPSY FINDINGS USED COMPLETE CAUSE OF CEATH 29 MANNER OF DEATH DID TOBACCO USE 28 IF FEMALE CONTRIBUTE TO DEATH 🔛 Not pregnant within past 12 months. Could not be determined □ Natural Bulcide ☐ Yes ☐ Probably Not pregnant, but pregnant within 42 days of death Prognant within one year of coath but time unknow, Accident Homicide Pending Investigation Urknown ☐ No Not pregnant, but pregnant 43 days to 1 year before death 🔲 Unknown if pregnant within the past 12 months 30. DATE OF INJURY (Month/Day/Year) 31 TIME OF INJURY 33. INJURY AT WORK? 32. PLACE OF INJURY (e.g. Decedents have; construction site; restourant, weeded area) AM PM ☐ Y68 ☐ No 34 LOCATION OF INJURY Street and Number Acartment Number ZIP Code State 35. DESCRIBE HOW INJURY OCCURRED 38, IF TRANSPORTATION INJURY, SPECIFY, Driver/Operator Pedestrian Passenger Other (Specify) 37 I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) 38. WAS MEDICAL EXAMINER OR 39. DATE PRONOUNCED (Morth/Day/Year) 40 TIME OF DEATH NO BULLA SEN, MIN WAS TOAL ONA CORONER CONTACTED? You X NO ☐ VŴ 図 bw 41 CERTIFIER (Check only one): Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated. Physician in altendance at time of death only - To the best of my knowledge, coch occurred at the time, date and place, and due to cause(s) and menner stated Medical Examiner/Coroner - On the basis of examination and/or invostigation, in my opinion ideath occurred at the time, date and place, and due to the cause(s) and mannor stated 42 NAME, ACDRESS AND ZIF CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) 43 PHYSICIAN'S LICENSE NUMBER MARR, SPLD 44 TITLE OF CERTIFIER 45 DAYE CERTIFIED (Munin/Day/Year) PHYSICIAN'S SIGNATURE NOT NEEDED AT THIS TIME PHYSICIAN IN CHARGE 46. SIGNATURE OF CERTIFIER

ILLINOIS DEPARTMENT OF PUBLIC HEALTH Division of Vital Records Electronic Death Registration System (EDRS)

ATTESTATION COPY

Fax Cover Sheet

May 22, 2008 1:32pm

Pages: 2 (Including this one)

TO CERTIFYING PHYSICIAN: S. L. Marr, MD

217-555-3412

Date & Time Sent:

OFFICE PHONE NO:

692291

FROM FUNERAL HOME: Derricks Funeral Home

OFFICE PHONE NO: 217-555-8759 **FAX NO:** 217-555-8758

Thank you for participating in the Illinois EDRS Fax Attestation Process. Please follow the steps below to complete the cause of death certification:

- Verify the decedent's Name, Date and Place of Death (items 1, 3, 4, 7a, 7b, 7c).
- Review the Attestation Copy and attest that the information is correct by affixing your signature in item 46.
- Fax the signed Attestaton Copy to the Funeral Home at 1-217-557-7104
- If any information is incorrect:
 - ° DO NOT SIGN

RE: TRACKING NO:

- Make corrections where needed
- ° Fax to the Funeral Home at 1-217-557-7104
- ° A corrected Attestation Copy will be faxed to you.
- If there are any questions or this was faxed to you in error, contact the funeral home listed on this cover sheet.

TRACKING NO: 692291 ILLINOIS CERTIFICATE OF DEATH									
1. DECEDENT'S LEGAL NAME (Include A	KAs if any) (First, Middle	e, Last)			2. SEX			onth/Day/Year) (Spell Month)	
KRIS K KROSS	- ^ C - ^ T A C T D D			T 5- UNIDED.	MALE		AY 21, 2008		
4. COUNTY OF DEATH	5a. AGE AT LAST BIR	IHDAY (Years) 5b. Ul Mont	NDER 1 YEAR ths Days	5c. UNDER	1 DAY Minutes	-	BIRTH (Month/D		
ALEXANDER 7a. CITY OR TOWN	98		7b. HOSPITAL OR	OTHER INSTITUTION	N NAME (If	not in either, give s	RUARY 2, 19		
EAST CAPE GIRARDEAU					,			,	
'E DEATH ACOUDDED IN A HACDITAL			EATH (Check only						
IF DEATH OCCURRED IN A HOSPITAL Inpatient Emergency Room/Out	patient Dead on Arriv	I	CURRED SOMEWH			cedent's Home	Other (Specify	SCENE	
ATTESTATION COPY									
Please verify the Cause of Death section below. If									
correct,									
sign in the b	ox at th	e botto	om rig	ht han	nd cc	rner	of th	is form	
21a. FUNERAL HOME NAME DERRICKS FH		REET AND NUMBER		CITY OR T	TOWN CAPE GIRA	STA ARDEA IL	ATE LINOIS	ZIP 62957	
21b. FUNERAL DIRECTOR'S SIGNATURE RICK R RORY					21c. FUNERA	L DIRECTOR'S I	ILLINOIS LICEN	ISE NUMBER	
22. LOCAL REGISTRAR'S SIGNATURE JAMES J JOKER					23. DATE FIL	ED WITH LOCAL	L REGISTRAR (Month/Day/Year)	
CAUSE OF DEATH (See Instruct 24. PART I. Enter the <i>chain</i> of events - dis respiratory arrest or ventricular fibrillation	seases, injuries or compl	ications - that directly o						OXIMATE INTERVAL EN ONSET AND DEATH	
Dementia Complex, indicate in Part I or			ıly one cause on a liı	ne. Add additional lir	nes if necessa	ry.			
or condition resulting in death)	Cardiac arre		oue to (or as a cons	sequence of):			$- \mid \frac{2}{} \mid$	minutes	
=	. <u>Rabies viral</u>		oue to (or as a cons	seguence off:			_ 3	days	
Enter the UNDERLYING CAUSE (disease or injury that initiated the	Fox bite	J	de to (or as a cons	sequence or).			4	days	
			ue to (or as a cons		1.	DE MACO ANI ALIE			
PART II. Enter other significant conditions	contributing to death	but not resulting in the	underlying cause gi	ven in PART I.	-	25. WAS AN AUT 26. WERE AUTO			
27. DID TOBACCO USE 28. IF F	FMALE:						CAUSE OF DEA	AUSE OF DEATH Yes No	
CONTRIBUTE TO DEATH Not pregnant within past 12 months Pregnant at time of death Natural Su						Suicide Homicide	Could not be determined Pending Investigation		
30. DATE OF INJURY (Month/Day/Year)	31. TIME O		2. PLACE OF INJUR			site; restaurant; wo	ooded area)	33. INJURY AT WORK?	
34. LOCATION OF INJURY Street and No	umber	Apartmen	t Number Cit	y or Town		State		ZIP Code	
35. DESCRIBE HOW INJURY OCCURRED:					36. IF TRAN	=	NJURY, SPECIF edestrian ther (Specify)	FY:	
37. I (DID) (DID NOT) ATTEND THE DECEA AND LAST SAW HIM/HER ALIVE ON	SED (Month/Day/Year)	38. WAS MEDICAL E. CORONER CONTA			<u> </u>	ED (Month/Day/Y		ME OF DEATH A.M. X P.M.	
41. CERTIFIER (Check only one):									
Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.									
 Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated. Medical Examiner/Coroner - 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. 									
42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) 43. PHYSICIAN'S LICENSE NUMBER									
MARR, S. L. MD 44. TITLE OF CERTIFIER									
PHYSICIAN IN ATTENDANCE		DO NOT WRITE OUTSIDE THE HEAVY LINE IN THE BOX BELOW.							
0001078619		46. SIGNATURE OF	CERTIFIER						

From DPH-DEV-TEST

G 2175575279 Tue May 22 17:34:11 2008

P.001/001

TRACKING NO: 692	291 ILLINOIS CERTIFIC	CATE OF DEA				
1 DECEDENTS LEGAL NAME (Include AKAs it any	(First, Middle, Lock)				TH (Menth/Day/Year) (Spot Month)	
KRIS K KROSS		55 UNCER 1 C	1411-1-7	MAY 21, :	onth/Dey/~eer)	
4, COUNTY OF DEATH 5a. AGE.	AT LAST BIRTHDAY (Years) 55, UNDER 1 YEAR Months Days	1		BRUARY		
ALEXANDER	98 76 HOSP TALC	OR CTHER INSTITUTION				
78 CITY OR TOWN EAST CAPE GIRARDEAU						
	76. PLACE OF DEATH (Check on IF DEATH OCCUPRED SOME)		HOSPITAL			
IF DEATH OCCURRED IN A HCSPITAL repation: Energency Room/Quipotient []	Dead on Arrival			⊠ ⊃iner (6	Bpodfy), SCENE	
ΑT	ESTATI	ONC	OP			
Please verify th	e Cause of Dea	th secti	on belo	w. Ii	f	
correct,						
	at the bottom rig	ght han	d corne	r of		
2'a FUNERAL HOME NAME DERRICKS FH	STREET AND NUMBER 222 SOUTH MAIN		APE GIRARDE/	STATE ILLINOIS		
2'b. FUNERAL DIRECTOR'S SIGNATURE RICK R RORY			16. FUNERAL DIRECTO 034010450			
22 LOCAL REGISTRAR'S SIGNATURE JAMES J JÖKER		2	3, OATE FILED WITH L	ocal Regis	TRAR (Morth/Day/Year)	
CAUSE OF DEATH (See Instructions and 24 PART I Emor the chain of events - diseases, in	unes or complications , that directly caused the death	DO NOT enter terminal	events such as cardine a	rrost.	APPROXIMATE INTERVAL BETWEEN ONSET AND CEATH	
respiratory arrost or vontribular librilistics without Demontic Complex, indicate in Party-of Part II. C	chawing obology. If the docadent had a dementia relation NOT ABBREVIATE. Enter only one cause on	e line. Add add lional int)\$ ¶ necessary.			
IMMEDIATE CAUSE (final disease)	rdiac arrest	consequence of):			2 minutes	
6	bies viral infection				3 days	
Enter the UNDERLYING CAUSE	x bite	consequence of):			4 days	
evente resulting in death) LAST C. 10		countdistre of:				
PART II Enter other significant conditions contribut	ing to death but not resulting in the underlying ones	io givan in PART).			PERFORMED? TYPS X No	
27 DID TOBACCO USE 28 IF FEMALU			COMPL	ETE CAUSE		
CONTRIBUTE TO DEATH Not prognant within past 12 months Prognant at time or obser					Suicide Could not be determined Momidide Rending Investigation	
30 DATE OF INJURY (Month/Day/Year)		JURY (e.g. Decesiónis fron		anr, waaqed are	3S. INJURY AT WORK?	
\$4, LOCATION OF INJURY Street and Number	Apartment Number	City or Town	Stat	ø	ZIP Code	
35. DESCRIBE HOW INJURY OCCURRED.			38. IF TRANSPORTATION DELIVORATION Passenger	ON INJURY, Pedesitian Citier (Spe		
37 T(DID) (DID NOT) ATTEND THE DECEASED IM AND LAST SAW HIM/HER ALIVE ON		Yes X No	PRONOLINGED (MORTIN		40 TIME OF DEATH 02,20	
41 CERTIFIER (Check only one)				 , '		
	best of my knowlodge, doeth decurred due to the caus · To the best of my knowledge, coath decurred at the t		cue to cause(s) and ma	nner steted		
	ramination and/or investigation, in my opinion death	occurred at the time, date	and place, and due to the		nd manner stated	
42 NAMÉ, ADDRESS AND ZIIF CODE OF PERSON MARR, S. L. M.D.	COMPLETING CAUSE OF DEATH (IIIM 24)			1	23456	
44 TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	DO NOT WE	TE OUTSINE THE	HEAVV	LINE IN THE BOX	
PHYSICIAN IN ATTENDANCE	5/20/2008		- COTODE INC	- 11509 1	ense na celle laeve	
0001079917	45. SIGNATURÉ OF CERTIFIES					