RECORDED DISTRICT 0201

REGISTER NUMBER 271

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RESIDENCE / NCHS / 4C / 4G / 7A / 7B / 9 / 10 / SI / 25 / 30 / 31 / 31B / QR / QS / QCOD / CANCER

DECEDENT

1. NAME: FIRST Bernard MIDDLE O. LAST BICKFORD
2. SEX: MALE [X] FEMALE [ ]
3A. DATE OF DEATH: MONTH June DAY 04 YEAR 1994
3B. HOUR: 7:40 A m
4A. PLACE OF DEATH: (Check only one) HOSPITAL DOA [ ] ER [ ] HOSPITAL OUTPATIENT [ ] HOSPITAL INPATIENT [ ] NURSING HOME [X] PRIVATE RESIDENCE [ ] OTHER (Specify)
4B. IF FACILITY, DATE ADMITTED: MONTH May DAY 09 YEAR 1994
4C. NAME OF FACILITY: (If not facility give address) Mercy Center for Health Services
4D. LOCALITY: (Check one and specify) CITY OF [X] VILLAGE OF [ ] TOWN OF [ ] Watertown
4E. COUNTY OF DEATH: Jefferson
4F. MEDICAL RECORD NO. 128188079
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO [ ] YES [ ]
5. DATE OF BIRTH: MONTH APR DAY 04 YEAR 1925
6. AGE: 69 yrs. IF UNDER 1 YEAR months days IF UNDER 1 DAY hours minutes
7A. CITY AND STATE OF BIRTH: (Country if not U.S.A.) Gouverneur, New York
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:
8. SERVED IN U.S. ARMED FORCES? NO [X] YES [ ] (Specify years)
9. RACE: (Black, White, etc.) White
10. HISPANIC ORIGIN? (If yes, specify) NO [X] YES [ ]
11. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)
12. SOCIAL SECURITY NUMBER: 128-18-8079
13. MARITAL STATUS: NEVER MARRIED [ ] MARRIED OR SEPARATED [ ] WIDOWED [X] DIVORCED [ ]
14. SURVIVING SPOUSE: (If wife, provide maiden name)
15A. USUAL OCCUPATION: (Do not enter retired) Owner/Operator
15B. KIND OF BUSINESS OR INDUSTRY: Recreational Golf
15C. NAME AND LOCALITY OF COMPANY OR FIRM: ForeXFour Golf Course, Gouverneur
16A. RESIDENCE, STATE: Florida
16B. COUNTY: Manatee
16C. LOCALITY: (Check one and specify) CITY OF [X] VILLAGE OF [ ] TOWN OF [ ] Bradenton
16D. STREET AND NUMBER OF RESIDENCE: 708-52nd Avenue West
16E. ZIP CODE: 34207
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES [ ] NO. IF NO, SPECIFY TOWN:

PARENTS

17. NAME OF FATHER: FIRST Robert MI O. LAST Bickford
18. MAIDEN NAME OF MOTHER: FIRST Edna MI V. LAST Fowler
19A. NAME OF INFORMANT: Leslie B. Bickford
19B. MAILING ADDRESS: (Include zip code) 527 N. Grover, Liberty, Missouri 64068

DISPOSITION

20A. BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: (Specify) Cremation MONTH JUN DAY 06 YEAR 1994
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Frederick Brothers Crematory, Theresa, New York
20C. LOCATION: (City or town and state)
21A. NAME AND ADDRESS OF FUNERAL HOME: Green Funeral Home, Inc. 33 Park Street, Gouverneur, New York 13642
21B. REGISTRATION NUMBER: 00801
22A. NAME OF FUNERAL DIRECTOR: Martha Green Storrin
22B. SIGNATURE OF FUNERAL DIRECTOR: [signature]
22C. REGISTRATION NUMBER: 05648
23A. SIGNATURE OF REGISTRAR: [signature]
23B. DATE FILED: MONTH 06 DAY 06 YEAR 94
24A. BURIAL OR REMOVAL PERMIT ISSUED BY: [signature]
24B. DATE ISSUED: MONTH 06 DAY 06 YEAR 94

CERTIFIER

ITEMS 25 - 33 COMPLETED BY CERTIFYING PHYSICIAN — OR — ITEMS 25 - 33 COMPLETED BY CORONER OR MEDICAL EXAMINER

25A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED.
SIGNATURE [signature] MD MONTH 6 DAY 6 YEAR 94
25B. THE PHYSICIAN ATTENDED THE DECEASED FROM MONTH 5 DAY 9 YEAR 94 TO MONTH 6 DAY 4 YEAR 94
25C. LAST SEEN ALIVE: MONTH 6 DAY 2 YEAR 94
25D. NAME OF ATTENDING PHYSICIAN: FRANK HARVEY MD.
25D. ATTENDING PHYSICIAN LICENSE NUMBER 171908
26. NAME AND ADDRESS OF CERTIFIER WHO SIGNED 25A JOHN L. GABBEY MD - 218 STONE ST - WATERTOWN N.Y. 13601

25A. ON THE BASIS OF INVESTIGATION AND SUCH EXAMINATIONS AS I FELT NECESSARY, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED. [ ] CORONER [ ] CORONER'S PHYSICIAN [ ] MEDICAL EXAMINER
SIGNATURE AND TITLE:
25B. PRONOUNCED DEAD ON MONTH DAY YEAR
25C. HOUR: m
25D. DATE SIGNED: MONTH DAY YEAR
25E. SIGNATURE OF CORONER OR CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER
25F. ME/COR. PHYS. LICENSE NUMBER

27. MANNER OF DEATH: NATURAL CAUSE [X] ACCIDENT [ ] HOMICIDE [ ] SUICIDE [ ] UNDETERMINED CIRCUMSTANCES [ ] PENDING INVESTIGATION [ ]
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? [X] NO [ ] YES
29A. AUTOPSY? NO [X] YES [ ]
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? [ ] NO [ ] YES

CAUSE OF DEATH

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).)

PART I.	Cause	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE: (A)	CARDIO - RESPIRATORY FAILURE	3 DAYS
DUE TO OR AS A CONSEQUENCE OF: (B)	CANCER OF MESOTHELIUM WITH METASTASES	10 MONTHS
DUE TO OR AS A CONSEQUENCE OF: (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
HOUR: m
31B. LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE:
31E. AT WORK? NO [ ] YES [ ]
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO [ ] YES [ ]
33A. IF FEMALE, WAS DECEDENT PREGNANT IN LAST 6 MONTHS? NO [ ] YES [ ]
33B. DATE OF DELIVERY: MONTH DAY YEAR

NAME OF DECEDENT: For use by physician or institution

DOH-1961 (1/91) VS-

EXHIBIT 5