

**CERTIFICATION OF VITAL RECORD**

**CITY OF FORT WORTH, TEXAS  
VITAL STATISTICS DIVISION**

STATE OF TEXAS

CERTIFICATE OF DEATH

STATE FILE NUMBER

Texas Department of Health — Bureau of Vital Statistics

1. NAME OF DECEASED (a) FIRST <b>MARJORIE</b>			(b) MIDDLE <b>JOHNSON</b>			(c) LAST <b>MILLER</b>			(d) MAIDEN <b>JOHNSON</b>		2. SEX <b>FEMALE</b>		3. DATE OF DEATH <b>JANUARY 12, 1999</b>	
4. DATE OF BIRTH <b>OCTOBER 19, 1925</b>			5. AGE (IN YEARS) <b>73</b>		IF UNDER 1 YR. MO DAYS		IF UNDER 1 DAY HOURS MIN		6. BIRTH PLACE (CITY & STATE OR FOREIGN COUNTRY) <b>BRECKENRIDGE, TEXAS</b>			7. SOCIAL SECURITY NO.		
8. RACE <b>WHITE</b>		9a. WAS THE DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		9b. IF YES, SPECIFY (MEXICAN, CUBAN, PUERTO RICAN, ETC.)			10. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. EDUCATION (SPECIFY HIGHEST GRADE COMPLETED, ELEM. OR SECONDARY (0-12) COLLEGE (13-16, 17+) <b>12</b>					
12. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			13. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME) <b>BRYCE VERNON MILLER, SR.</b>			14a. DECEDENT'S USUAL OCCUPATION <b>HOMEMAKER</b>			14b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKING</b>					
15a. RESIDENCE STREET ADDRESS <b>RT. 4 BOX 120</b>									15b. CITY OR TOWN <b>DUBLIN</b>					
15c. COUNTY <b>ERATH</b>			15d. STATE <b>TEXAS</b>			15e. ZIP CODE <b>76446</b>			15f. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
16. FATHER'S NAME <b>PERCY GLENN JOHNSON</b>						17. MOTHER'S MAIDEN NAME <b>NELL MCKEE</b>								
18. PLACE OF DEATH (CHECK ONLY ONE)														
HOSPITAL: <input checked="" type="checkbox"/> INPATIENT <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> NURSING HOME <input type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (SPECIFY)														
19. COUNTY OF DEATH <b>TARRANT</b>			20. CITY OR TOWN (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO.) <b>FORT WORTH</b>			21. NAME OF HOSPITAL OR INSTITUTION (If not in institution, show street address) <b>HARRIS METHODIST HOSPITAL</b>								
22. INFORMANT — SIGNATURE & RELATIONSHIP <b>BRYCE V. MILLER</b>									23. MAILING ADDRESS OF INFORMANT <b>HUSBAND RT. 4, BOX 120, DUBLIN, TX. 76446</b>					
24. METHOD OF DISPOSITION <input type="checkbox"/> BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> DONATION <input type="checkbox"/> OTHER (SPECIFY)			25a. PLACE OF DISPOSITION (NAME OF CEMETERY, CREMATORY OR OTHER PLACE) <b>CREMATION SERVICES</b>			25b. Section Block Lot Space			29. NAME & ADDRESS OF FUNERAL HOME <b>HARRELL FUNERAL HOME P.O. DRAWER 0260 DUBLIN, TEXAS 76446</b>					
			26. LOCATION (CITY, STATE) <b>FORT WORTH, TEXAS</b>			27. SIGNATURE OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH <i>C. T. Pounds - Tucker</i> 9161			28. DATE OF DISPOSITION <b>1-15-1999</b>					
30. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING 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. <input type="checkbox"/> MEDICAL EXAMINER } ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION, DEATH OCCURRED AT THE TIME, DATE, PLACE, AND DUE TO THE <input type="checkbox"/> JUSTICE OF THE PEACE } CAUSE(S) AND MANNER AS STATED.														
31. SIGNATURE & TITLE OF CERTIFIER <i>John R. Burke, M.D.</i>									32. DATE SIGNED MO DAY YEAR <b>1 14 99</b>			33. TIME OF DEATH <b>8:48 P. M.</b>		
34. PRINTED NAME & ADDRESS OF CERTIFIER <b>JOHN BURKE M.D. 1521 COOPER, FORT WORTH, TEXAS 76104</b>														
35. PART 1 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. <i>respiratory failure</i>												years		
DUPLICATE TO (OR AS A LIKELY CONSEQUENCE OF):														
b. <i>chronic obstructive pulmonary disease</i>														
DUPLICATE TO (OR AS A LIKELY CONSEQUENCE OF):														
c. _____														
DUPLICATE TO (OR AS A LIKELY CONSEQUENCE OF):														
d. _____														
35. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1 (i.e., substance abuse, diabetes, smoking, etc.)									36a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			36b. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
37. DID TOBACCO USE CONTRIBUTE TO DEATH <input checked="" type="checkbox"/> YES <input type="checkbox"/> PROBABLY <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			38. DID ALCOHOL USE CONTRIBUTE TO DEATH <input type="checkbox"/> YES <input type="checkbox"/> PROBABLY <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			39. WAS DECEDENT PREGNANT AT TIME OF DEATH <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK WITHIN LAST 12 MO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK								
40. MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT			41a. DATE OF INJURY		41b. TIME OF INJURY <b>M.</b>		41c. INJURY AT WORK <input type="checkbox"/> YES <input type="checkbox"/> NO		41d. PLACE OF INJURY — AT HOME, FARM, STREET, FACTORY, OFFICE, ETC. (SPECIFY)					
41e. LOCATION (STREET AND NUMBER, CITY OR TOWN, STATE)														

WARNING: for knowingly making a false statement in this form can be 2-10 years in prison, or a fine of up to \$10,000. (Health and Safety Code, Sec. 195, 1989)