STATE OF NEW JERSEY

REG-18
APR 04

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
CERTIFICATE OF DEATH

STATE FILE NUMBER: 0056756

Time of Death: 18:13 ☐AM ☒PM
Date of Death: 10-29-05
Name of Decedent as Known by Physician: Sauter, Joyce

TO BE COMPLETED BY FUNERAL DIRECTOR

1a. Legal Name of Decedent *(First, Middle, Last)*: JOYCE B. SAUTER
1b. Also Known As (AKA), If Any *(First, Middle, Last)*: ---
2. Sex: Fe
3. Social Security Number: [redacted]
4a. Age-Last Birthday: -61- Years
4b. Under 1 Year: --- Months / Days
4c. Under 1 Day: - Hours / Minutes
5. Date of Birth *(Mo/Dy/Yr)*: 11/9/1943
6. Birthplace *(City & State/Foreign Country)*: Fall River, Mass.
7a. Residence-State: NJ
7b. County: Middlesex
7c. Municipality/City: Sayreville
7d. Street and Number: [redacted]
7e. Apt. No.: --
7f. Zip Code: 08879 [redacted]
7g. Inside City Limits? ☒Yes ☐No
8a. Ever in US Armed Forces? ☐Yes ☒No ☐Unk.
b. If Yes, Name of War:
c. War Service Dates (From/To):
9. Marital Status at Time of Death: ☐Never Married ☒Married ☐Married but Separated ☐Divorced ☐Widowed ☐Unknown
9a. Surviving Spouse Name *(If wife, name prior to first marriage)*: [redacted]
10a. Was Decedent Ever Registered in a Domestic Partnership? ☐Yes ☒No
10b. If Yes, Status at Time of Death: ☐Currently Registered in a Domestic Partnership ☐Previous Domestic Partnership, Partner Deceased ☐Previous Domestic Partnership, Legally Terminated
10c. Surviving Domestic Partner Name: N/A
11. Father's Name *(First, Middle, Last)*: William H. Strouse
12. Mother's Name Prior to First Marriage *(First, Middle, Last)*: Lillian M. Carpenter
13a. Name of Informant: [redacted]
13b. Relationship to Decedent: [redacted]
13c. Mailing Address *(Street and Number, City, State, Zip Code)*: [redacted]
14. Method of Disposition: ☐Burial ☒Cremation ☐Removal from State ☐Other *(Specify)*: ☐Donation ☐Entombment
15. Place of Disposition *(Name of cemetery, crematory, other place)*: [redacted]
16. Location-City or Town and State: [redacted]
17. Name and Complete Address of Funeral Facility: [redacted]
18. Signature of Funeral Director: [signature]
19. NJ License Number: NJ3381
20. Decedent Education – *Highest degree or level of school completed at time of death.* ☐Grade 8 or less ☒Grade 9-12; no diploma ☐High school graduate or GED ☐Some college credit, no degree ☐Associate degree (AA, AS) ☐Bachelor's degree (BA, AB, BS) ☐Master's degree (MA, MS, MEd, MSW) ☐Doctorate (PhD, EdD) or Professional degree (MD, DDS, JD)
21. Decedent of Hispanic Origin? *Check one or more boxes that best describe if decedent is Spanish/Hispanic/Latino. Check "No" box if decedent is not Spanish/Hispanic/Latino.* ☒No, Not Spanish/Hispanic/Latino ☐Yes, Mexican, Mexican American, Chicano ☐Yes, Puerto Rican ☐Yes, Cuban ☐Yes, Other Spanish/Hispanic/Latino *(Specify)*:
22. Decedent Race – *Check one or more boxes to indicate what race the decedent considered himself/herself to be.* ☒White ☐Black or African American ☐American Indian or Alaska Native *(Enrolled or principal tribe)* ☐Asian Indian ☐Filipino ☐Korean ☐Chinese ☐Japanese ☐Vietnamese ☐Other Asian *(Specify)* ☐Native Hawaiian ☐Guamanian or Chamorro ☐Samoan ☐Other Pacific Islander *(Specify)* ☐Other *(Specify)*
23. Occupation of Decedent *(Type of work done most of life, even if retired)*: Nursing Home Aide
24. Kind of Business/Industry: Health Care
25. Name and Address of Last Employer: [redacted]

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Place of Accident
Cross Class
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Record Contains Amendment

TO BE COMPLETED BY MEDICAL CERTIFIER

ITEMS 26-30 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
26. Date Pronounced Dead *(Mo/Day/Yr)*: 10-29-05
27. Time Pronounced Dead: 18:13 ☐AM ☒PM
28. Signature of Person Pronouncing Death *(If other than Certifier)*:
29. License Number:
30. Date Signed *(Mo/Day/Yr)*:
31. Date of Death *(Mo/Day/Yr)*: 10-29-05
32. Time of Death: 18:13 ☐AM ☒PM
33. Was Medical Examiner Contacted? ☒Yes ☐No
34. PLACE OF DEATH *(Check only one)*: If Death Occurred in a Hospital: ☐Inpatient ☐Emergency Room or Outpatient ☐Dead on Arrival. If Death Occurred Somewhere Other Than a Hospital: ☐Hospice Facility ☐Nursing Home/Long Term Care Facility ☒Decedent's Home ☐Other *(Specify)*:
35a. Facility Name *(If not institution, give street and number)*: [redacted]
35b. Municipality: [redacted]
35c. County: Middlesex

CAUSE OF DEATH
36a. PART I – IMMEDIATE CAUSE – final disease or condition resulting in death. Subsequently list conditions, if any, leading to the cause listed on Line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.
Immediate Cause – *(Enter chain of events (diseases, injuries, or complications) that directly caused death. DO NOT enter terminal events such as cardiac arrest, or ventricular fibrillation without showing etiology. DO NOT ABBREVIATE. Enter only one cause per line. Add additional lines if necessary.)*

	Cause	Interval Between Onset and Death
a.	Pending Toxicology	
b. Due to *(or as a consequence of)*:		
c. Due to *(or as a consequence of)*:		
d. Due to *(or as a consequence of)*:		

36b. PART II – Enter other significant conditions contributing to death but not resulting in underlying cause given in PART I.
37. Was an Autopsy Performed? ☐Yes ☒No
38. Were Autopsy Findings Available to Complete Cause of Death? ☐Yes ☒No
39. Date of Injury *(Mo/Day/Yr)*:
40. Time of Injury: ☐AM ☐PM
41. Place of Injury *(e.g., home, construction site, restaurant)*:
42. Injury at Work? ☐Yes ☐No
43a. Location of Injury (Number and Street, Zip Code)
43b. Municipality
43c. County
43d. State
44. Describe How Injury Occurred
45. If Transportation Injury: ☐Driver/Operator ☐Passenger ☐Pedestrian ☐Other (Specify):
46. Manner of Death: ☐Natural ☐Accident ☐Suicide ☐Homicide ☒Pending Investigation ☐Could not be Determined
47. Did Decedent Have Diabetes? ☐Yes ☐No ☐Unknown
48. Did Tobacco Use Contribute to Death? ☐Yes ☐Probably ☒No ☐Unknown
49. If Female: ☒Not pregnant within past year ☐Pregnant at time of death ☐Not pregnant, but pregnant within 42 days of death ☐Not pregnant, but pregnant 43 days to 1 year before death ☐Unknown if pregnant within the past year
50. Certifier (Check only one)
51. Name, Address and Zip Code of Certifier: ~~Frederick J. DiCarlo, MD, [illegible] Livingston Ave, Bldg #300 North Brunswick, NJ [illegible]~~
Signature of Certifier: Frederick J. DiCarlo, MD
License Number:
Date Certified *(Mo/Day/Yr)*: 10-31-05
Local File Number

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