

OCT 14 2004

## STATE REGISTRAR OF VITAL RECORDS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Unpend Item 23a c, pt. 11, 27, 28a 1 per me 6856 10-12-04 Eas  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2004 277746

1. Decedent's Name (First, Middle, Last) John Ward Hoffman		2. Date of Death Month Day Year AUGUST 11, 2004		3. Time of Death 12:59p. M	
4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) June 23, 1965	
9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Montgomery	
10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number	
10f. Zip Code		10g. Citizen of What Country? United States		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Custom Office Design Company	
17. Father's Name (First, Middle, Last) John W. Hoffman		18. Mother's Name (First, Middle, Maiden Surname) Frances Yates		19a. Informant's Name/Relationship (Type, Print) Susan M. Hoffman/ Wife	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.	
20c. Location - City or Town, State Bethesda, Maryland		21. Signature of Funeral Service Licensee M00689		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Ave., Rockville, MD 20850	
23a. Part I. Enter the disease, 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. Immediate Cause (Final disease or condition resulting in death) a. Intracerebral infarct Due to (or as a consequence of): b. Dissection of carotid artery Due to (or as a consequence of): c. Cervical manipulation Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 8-5-04		28b. Time of Injury Unknown M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject had chiropractic cervical manipulation		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Office	
28f. Location (Street and Number or Rural Route Number, City or Town, State) 4701 Randolph Rd., Rockville, MD		29a. Certifier (Check only one) 1 <input 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. 2 <input checked="" type="checkbox"/> Medical Examiner: 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.		29b. Signature and title of certifier O.C.M.E.	
29c. License number		29d. Date signed (Month, Day, Year) AUGUST 13, 2004		29e. Date of Death (Month, Day, Year) AUGUST 11, 2004	