

(INSTRUCTIONS ON REVERSE SIDE)



The Commonwealth of Massachusetts

STATE CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

0533

STATE USE ONLY

40 Hosp

5 Type

8 Hosp Race

10 Age

15 Resid

15 Out-State

23 Disp

31-32 Autop

34 Manner

35a Work Inj

38f Place

38-37 Cert

40a Pron

DECEASED

INFORMANT

DISPOSITION

CERTIFIER

DECEASED NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (Mo., Day, Yr.)	
Edward		Moore		Kennedy	M	Aug. 25, 2009	
PLACE OF DEATH (City/Town):		COUNTY OF DEATH		HOSPITAL OR OTHER INSTITUTION - Name (If not in author, give street and number)			
Barnstable		Barnstable					
PLACE OF DEATH (Check only one):		OTHER		SOCIAL SECURITY NUMBER		IF US WAR VETERAN SPECIFY WAR	
<input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA		<input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		[REDACTED]		7 Korea	
WAS DECEASED OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.)		RACE (Specify)		DECEDENT'S EDUCATION (Highest Grade Completed)			
<input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		White		Elementary Sch (0-12) College (13-16)		5+	
AGE - Last Birthday (Yrs.)		UNDER 1 YEAR		DATE OF BIRTH (Mo., Day, Yr.)		BIRTHPLACE (City and State or Foreign Country)	
77		MOS. DAYS HOURS MINS		Feb. 22, 1932		Boston, MA	
MARRIED, NEVER MARRIED WIDOWED OR DIVORCED		LAST SPOUSE (If wife, give maiden name)		USUAL OCCUPATION (Prior - If Retired)		KIND OF BUSINESS OR INDUSTRY	
Married		Victoria A. Reggie		U. S. Senator		U. S. Government	
RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY							
FATHER - FULL NAME		STATE OF BIRTH (If not in US, name country)		MOTHER - NAME (GIVEN) (MAIDEN)		STATE OF BIRTH (If not in the US, name country)	
16 Joseph P. Kennedy Sr.		17 MA		18 Rose Fitzgerald		19 MA	
INFORMANT'S NAME				MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE		RELATIONSHIP	
20 Victoria Anne Kennedy						21 Wife	
23 METHOD OF IMMEDIATE DISPOSITION		FUNERAL SERVICE LICENSER OR OTHER DESIGNEE		LICENSE #			
<input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION		Mark W. Tomkins					
<input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> REMOVAL FROM STATE							
<input type="checkbox"/> DONATION <input type="checkbox"/> OTH. SPEC.							
PLACE OF DISPOSITION (Name of Cemetery, Crematory or other)		LOCATION (City/Town, State)					
24a Arlington National Cemetery		24b Arlington, VA					
DATE OF DISPOSITION (Mo., Day, Yr.)		NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE					
27 Aug. 29, 2009		28					
29 PART I - Enter the disease, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d) PRINT OR TYPE LEGIBLY.		IMMEDIATE CAUSE (Final disease or condition resulting in death)		DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death	
		GLIOMA				15 months	
		Sequently that conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST		DUE TO (OR AS A CONSEQUENCE OF)			
PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.				31 WAS AUTOPSY PERFORMED? (Yes or No)		32 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)	
				No			
30 MED. EXAM. NOTIFIED? (Yes or No)		34 MANNER OF DEATH		DATE OF INJURY (Mo., Day, Yr.)		TIME OF INJURY	
YES		<input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> HOMICIDE <input type="checkbox"/> COULD NOT BE DETERMINED					
		<input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> PENDING INVESTIGATION					
33 DESCRIBE HOW INJURY OCCURRED		PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.) Specify		LOCATION (No. & St. City/Town, State)		35b INJURY AT WORK (Yes or No)	
						M 35a	
35d To be Completed by CERTIFYING PHYSICIAN ONLY		36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title)		37a 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) stated. (Signature and Title)		HOUR OF DEATH	
		36b DATE SIGNED (Mo., Day, Yr.)		36c HOUR OF DEATH			
		36d NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER		36e		37c PRONOUNCED DEAD (Mo., Day, Yr.)	
		36d				37d	
		NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print)				37e LICENSE NO. OF CERTIFIER	
		36d LAURENCE J. RONAN MASSACHUSETTS GENERAL HOSPITAL BOSTON, MA				37e	
38 WAS THERE A PRONOUNCEMENT FORHT? (Yes or No)		39 IF YES, DATE PRONOUNCED		40 NAME OF PRONOUNCER		TITLE	
NO		40a		40b		<input type="checkbox"/> R.N. <input type="checkbox"/> P.A. <input type="checkbox"/> N.P.	
DATE BURIAL PERMIT ISSUED		RECEIVED BY THE STATE DEPARTMENT OF HEALTH		DATE OF RECORD			
Aug. 27, 2009		[Signature]		AUG. 31, 2009			

Pronouncement of Death Form (R-302) on File:

PERMANENT BLACK INK ONLY

R-301-05

I, the undersigned, hereby certify that I am the Town Clerk for the Town of Barnstable that, as such, I have custody of the records of births, marriages and deaths, required by law to be kept in my office; and I do hereby certify that the above is a true copy from said records. WITNESS: My hand and the SEAL OF THE TOWN OF BARNSTABLE. A TRUE COPY ATTEST: at Barnstable, Massachusetts

[Signature] Linda Hutchenrider, Town Clerk, Barnstable

(If the Seal is not raised, this document has been illegally copied - do not accept it.)