

ORIGINAL



# SCCID

SOUTH CAROLINA COMMISSION ON INDIGENT DEFENSE

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Robert M. Dudek, Chief Appellate Defender  
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June 17, 2014

**RECEIVED**

JUN 18 2014

**SC Court of Appeals**

Honorable Jenny Abbott Kitchings  
Clerk, South Carolina Court of Appeals  
Post Office Box 11629  
Columbia, South Carolina 29211

Re: Raymond Kelly v. State of South Carolina

Dear Ms. Kitchings:

On June 12, 2014, this Court denied the Johnson petition for writ of certiorari that I filed on behalf of Mr. Kelly. Prior to the Court denying the petition, I learned that my client passed away in January of 2014, and I just received a copy of his death certificate which I have enclosed. I simply wanted to make the Court aware of the fact that Mr. Kelly is now deceased. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Kathrine H. Hudgins  
Appellate Defender

KHH/brr

Enclosure

cc: Suzanne H. White, Esquire

NAME OF DECEDENT  
For use by physician or institution

Items 1-23c To Be Completed/Verified By: FUNERAL DIRECTOR

Items 24-49 To Be Completed By: MEDICAL CERTIFIER

1. DECEDENT'S LEGAL NAME (Include AKA's, if any) (First, Middle, Last) Raymond Thomas Kelley					2. SEX Male	3. SOCIAL SECURITY NUMBER None
4a. AGE-Last Birthday (Years) 71	4b. UNDER 1 YEAR Months Days	4c. UNDER 1 DAY Hours Minutes	5. DATE OF BIRTH (MM/DD/YYYY) 01/29/1942	6. BIRTHPLACE (City and State or Foreign Country) Kentucky		
7a. RESIDENCE-STATE South Carolina		7b. COUNTY Richland		7c. CITY OR TOWN Columbia		
7d. STREET AND NUMBER 4460 Broad River Road				7e. APT. NO.	7f. ZIP CODE 29210	7g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8. EVER IN US ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)		
11. FATHER'S NAME (First, Middle, Last) Unknown			12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Unknown			
13a. INFORMANT'S NAME Michael Brown		13b. RELATIONSHIP TO DECEDENT Chaplain		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 4460 Broad River Road Columbia, South Carolina 29210		
14. PLACE OF DEATH (Check only one: see instructions)						
IF DEATH OCCURRED IN HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival						
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify)						
15. FACILITY NAME (If not institution, give street and number) Palmetto Health Richland				16. CITY OR TOWN, STATE AND ZIP CODE Columbia, South Carolina 29203		17. COUNTY OF DEATH Richland
18. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from state <input type="checkbox"/> Other (Specify)			19. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place) Upstate Crematory			
20. LOCATION-CITY, TOWN AND STATE Roebuck, South Carolina			21. NAME AND ADDRESS OF FUNERAL FACILITY Dunbar Funeral Home			
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT James E. Reppart (Electronically Verified)			23. LICENSE NUMBER (Of Licensee) 2302	690 Southport Road Roebuck SC 29376		
23a. EMBALMER (Signature)			23b. EMBALMER LICENSE NUMBER	23c. LICENSE NUMBER (Of Facility) 453		
ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH			24. DATE PRONOUNCED DEAD (MM/DD/YYYY) 01/21/2014	25. TIME PRONOUNCED DEAD 16:02		
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)			27. LICENSE NUMBER	28. DATE SIGNED (mm/dd/yyyy)		
29. ACTUAL OR PRESUMED DATE OF DEATH (Spell Month) January 21, 2014			30. ACTUAL OR PRESUMED TIME OF DEATH 04:02 PM		31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
32. PART I. Enter the <u>chain of events</u> - disease, injuries, or complications - that directly caused the death. DO NOT enter terminal events cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Multi-Organ Failure Due to (or as a consequence of): Sequentially 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) b. Cirrhosis of the Liver Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): LAST						
PART II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I.						
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown			36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to one year before death <input type="checkbox"/> Unknown if pregnant within the past year		37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined	
38. DATE OF INJURY (Spell Month)		39. TIME OF INJURY	40. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)			41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
42. LOCATION OF INJURY: State: _____ City or Town: _____ County: _____						
43. DESCRIBE HOW INJURY OCCURRED: Street & Number: _____ Apartment Number: _____ Zip Code: _____			44. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)			
45. CERTIFIER (Check only one) <input type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing and Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated <input checked="" type="checkbox"/> Coroner/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 Signature of certifier: Ann Joe (Electronically Certified)						
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32) Ann Joe, 1931 Pineview Drive Columbia South Carolina 29209				46a. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER		
47. TITLE OF CERTIFIER Deputy Coroner		48. LICENSE NUMBER		49. DATE CERTIFIED (MM/DD/YYYY) 01/24/2014		50. FOR REGISTRAR ONLY- DATE FILED (MM/DD/YYYY) 01/27/2014
51. DECEDENT'S EDUCATION- Check the box that best describes the highest degree or level of school completed at		52. DECEDENT OF HISPANIC ORIGIN?-Check the box that best describes whether the decedent is Spanish/Hispanic/Latino/ Latina. Check the "No" box if		53. DECEDENT'S RACE-(Check one or more races to indicate what the decedent considered himself or herself to be) <input checked="" type="checkbox"/> White		