State of South Carolina
Department of Health and Environmental Control

CERTIFICATE OF DEATH

State Birth Number: 009620

State File Number: 18 001627

NAME OF DECEDENT
For use by physician or institution

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

1. DECEDENT'S LEGAL NAME (Include AKA's, if any) (First, Middle, Last): BENNIE RAY BROWN
2. SEX: Male
3. SOCIAL SECURITY NUMBER: [redacted]
4a. AGE-Last Birthday (Years): 45
4b. UNDER 1 YEAR Months / Days:
4c. UNDER 1 DAY Hours / Minutes:
5. DATE OF BIRTH (MMDDCCYY): [redacted]
6. BIRTHPLACE (City and State or Foreign Country): Laurens County NOS, SC
7a. RESIDENCE-STATE: South Carolina
7b. COUNTY: Greenville
7c. CITY OR TOWN: Pelzer
7d. STREET AND NUMBER: [redacted]
7e. APT. NO.:
7f. ZIP CODE: 29669
7g. INSIDE CITY LIMITS? ☐ Yes ☒ No
8. EVER IN US ARMED FORCES? ☐ Yes ☒ No
9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☒ Unknown
10. SURVIVING SPOUSE'S NAME (If Wife, give name prior to first marriage):
11. FATHER'S NAME (First, Middle, Last): BENNIE RAY BROWN
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): ERNESTINE MOORE
13a. INFORMANT'S NAME: KENNETH BROWN
13b. RELATIONSHIP TO DECEDENT: UNCLE
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): [redacted]
14. PLACE OF DEATH (Check only one: see instructions)
IF DEATH OCCURRED IN HOSPITAL: ☐ Inpatient ☐ Emergency Room/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) PERRY CORRECTION CENTER
15. FACILITY NAME (If not institution, give street and number): 430 OAKLAWN Road
16. CITY OR TOWN, STATE AND ZIP CODE: Pelzer South Carolina 29669
17. COUNTY OF DEATH: Greenville
18. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from state ☐ Other (Specify)
19. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place): BETHEL MISSIONARY BAPTIST CHURCH CEMETERY
20. LOCATION-CITY, TOWN AND STATE: Clinton, South Carolina
21. NAME AND ADDRESS OF FUNERAL FACILITY: Childs Funeral Home Inc
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT: F. Ann G Childs (Electronically Verified)
23. LICENSE NUMBER (Of Licensee): 1525
301 W. Carolina Ave/PO Box 1087 Clinton,SC 29325
23a. EMBALMER (Signature): ZEBBIE GOUDLOCK
23b. EMBALMER LICENSE NUMBER: 1567
23c. LICENSE NUMBER (Of Facility): 86

Items 24-49 To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
24. DATE PRONOUNCED DEAD (MM/DD/YYYY): 01/12/2018
25. TIME PRONOUNCED DEAD: 23:01
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 12, 2018
30. ACTUAL OR PRESUMED TIME OF DEATH: 23:01
31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? ☒ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART 1. Enter the chain of events - 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.

		Approximate Interval Onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Atherosclerotic Cardiovascular Disease	
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) LAST b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		
Due to (or as a consequence of):		

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I: Cardiomegaly

33. WAS AN AUTOPSY PERFORMED? ☒ Yes ☐ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☒ Yes ☐ No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☒ Unknown
36. 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 one year before death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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? ☐ Yes ☐ No
42. LOCATION OF INJURY: State: City or Town: County: Street & Number: Apartment Number: Zip Code:
43. DESCRIBE HOW INJURY OCCURRED:
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)
45. CERTIFIER (Check only one)
☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ 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
☒ 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: Gary Sessions (Electronically Certified)
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): Gary Sessions, 1190 West Faris Road Greenville South Carolina 29605
46a. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER:
47. TITLE OF CERTIFIER: Deputy Coroner
48. LICENSE NUMBER:
49. DATE CERTIFIED (MM/DD/YYYY): 01/13/2018
50. FOR REGISTRAR ONLY- DATE FILED (MM/DD/YYYY): 01/16/2018

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51. DECEDENT'S EDUCATION- Check the box that best describes the highest
52. DECEDENT OF HISPANIC ORIGIN?-Check the box that best describes whether the decedent is
53. DECEDENT'S RACE-(Check one or more races to indicate what the decedent considered himself or herself to be)