

State Birth Number  
039155

State of South Carolina  
Department of Health and Environmental Control  
**CERTIFICATE OF DEATH**

State File Number  
20 007825

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) Keishawn Omar McManus				2. SEX Male	3. SOCIAL SECURITY NUMBER [REDACTED]
4a. AGE-Last Birthday (Years) 27	4b. UNDER 1 YEAR Months Days	4c. UNDER 1 DAY Hours Minutes	5. DATE OF BIRTH (MM/DD/YYYY) [REDACTED]	6. BIRTHPLACE (City and State or Foreign Country) Lancaster County NOS, SC	
7a. RESIDENCE-STATE South Carolina		7b. COUNTY Lancaster		7c. CITY OR TOWN Lancaster	
7d. STREET AND NUMBER 180 Clyburn Drive		7e. APT. NO.	7f. ZIP CODE	7g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Divorced <input checked="" 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) NA			12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Deanna McManus		
13a. INFORMANT'S NAME Deanna Shaw		13b. RELATIONSHIP TO DECEDENT Mother		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 180 Clyburn Drive Lancaster, South Carolina	
14. PLACE OF DEATH (Check only one: see Instructions)					
IF DEATH OCCURRED IN HOSPITAL: <input 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 checked="" type="checkbox"/> Other (Specify) Perry Correctional		
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 <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from state <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)			19. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place) Rose Hill Bapt Church		
20. LOCATION-CITY, TOWN AND STATE Pageland, South Carolina			21. NAME AND ADDRESS OF FUNERAL FACILITY Blakely's Funeral & Cremation Service, LLC (NC)		
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT Mary L Blakely (Signature on File)			23. LICENSE NUMBER (Of Licensee) 3144 (NC)		714 East Franklin Street Monroe NC 28112
23a. EMBALMER (Signature) Jonathan Holland		23b. EMBALMER LICENSE NUMBER FS 2970 (NC)		23c. LICENSE NUMBER (Of Facility) 909	
ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH			24. DATE PRONOUNCED DEAD (MM/DD/YYYY) 01/31/2020		25. TIME PRONOUNCED DEAD 07:02 AM
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 31, 2020			30. ACTUAL OR PRESUMED TIME OF DEATH Est 00:10 to 01:10 AM		31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Hanging 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.					
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input 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 type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
38. DATE OF INJURY (Spell Month) January 31, 2020		39. TIME OF INJURY Est 00:10 to 01:10 AM		40. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) Perry Correctional	
42. LOCATION OF INJURY: State: South Carolina City or Town: Pelzer County: Greenville					
Street and Number: 430 Oaklawn Road Apartment Number: Zip Code: 29669					
43. DESCRIBE HOW INJURY OCCURRED: Hanged Self				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: Shelton E. England (Electronically Certified)					
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32) Shelton E. England, 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) 02/24/2020	
				50. FOR REGISTRAR ONLY- DATE FILED (MM/DD/YYYY) 03/03/2020	
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)	