

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
N.C. VITAL RECORDS

CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 084-00 LOCAL NO. 429 COUNTY OF DEATH Select Stanly STATE FILE NO.

TYPEPRINT IN PERMANENT BLACK, BLUE, BLACK OR BLUE INK NAME OF DECEDENT (For use by physician, institution or Medical Examiner) BILLY BINGHAM	DECEDENT'S LEGAL NAME					
	1a. FIRST Billy		1b. MIDDLE Richard		1c. LAST Bingham	
	1d. SUFFIX Jr.		1e. LAST NAME PRIOR TO FIRST MARRIAGE			
	2. SEX M		3a. AGE-LAST BIRTHDAY (Yrs) 61		3b. UNDER 1 YEAR Months: Days: Hours: Minutes:	
	3c. UNDER 1 DAY			4. DATE OF BIRTH (Month/Day/Year) 11-30-58		5. BIRTHPLACE (County/State or Foreign Country) Gaston/ NC
	6. DATE OF DEATH (Month/Day/Year) 8-3-2020					
	PLACE OF DEATH (Check only one)					
	7a. IF DEATH OCCURRED IN A HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			7b. 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) Albemarle Correctional		
	7c. FACILITY NAME (if not institution, give street and number) 44150 Airport Rd.				7d. CITY OR TOWN New London	
	7e. COUNTY OF DEATH Select Stanly					
8. MARITAL STATUS <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		9. SURVIVING SPOUSE (Give name prior to first marriage)		10a. DECEDENT'S USUAL OCCUPATION (Do not use retired) Repairman		
10b. KIND OF BUSINESS/INDUSTRY Electronic Repair						
11. SOCIAL SECURITY NUMBER 237-13-4406		12a. RESIDENCE-STATE OR FOREIGN COUNTRY North Carolina		12b. COUNTY Stanly		
12c. CITY OR TOWN New London						
12d. STREET AND NUMBER 44150 Airport Road		12e. INSIDE CITY LIMITS <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		12f. ZIP CODE 28127		
13. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
14. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th-12th grade; no diploma <input checked="" type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)			15. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify)		16. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input checked="" type="checkbox"/> White <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or minimal tribal) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese	
17. FATHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage) Billy Richard Bingham			18. MOTHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage) Dorothy Jean Quinn			
19a. INFORMANT'S NAME Sherman Bingham		19b. RELATIONSHIP TO DECEDENT Uncle		19c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 1037 Bethlehem Road Old Fort, North Carolina 28762		
20a. 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)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) Beam Funeral Service & Crematory		20c. LOCATION (City or Town and State) Marion, NC		
21a. SIGNATURE OF FUNERAL DIRECTOR Chad L. Bee		21b. LICENSE NUMBER FS 2123		21c. NAME OF EMBALMER Not embalmed		
21d. LICENSE NUMBER		22. NAME AND ADDRESS OF FUNERAL HOME Beam Funeral Service & Crematory, 2170 Rutherford Rd., Marion, NC 28752				
23. Part I. Enter the chain of events (diseases, injuries or complications) that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology on lines b, c and/or d. Enter only one cause on a line. DO NOT ABBREVIATE.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia 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. COVID-19 virus 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. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, emphysema, COPD				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending <input type="checkbox"/> Suicide <input type="checkbox"/> Cannot be determined		26a. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. TIME OF DEATH (Approximate) 0031		
26b. IF YES <input type="checkbox"/> Declined by Medical Examiner		28. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		29. IF FEMALE: <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		
30. DATE PRONOUNCED (Month/Day/Year)		31a. DATE OF INJURY (Month/Day/Year)		31b. TIME OF INJURY		
31c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		31d. PLACE OF INJURY—at home, farm, street, factory, office, building, etc.				
31e. IF TRANSPORTATION INJURY SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		31f. DESCRIBE HOW INJURY OCCURRED				
31g. LOCATION OF INJURY (Street/Number/City/State)						
32. CERTIFIER (Check only one). <input type="checkbox"/> Certifying physician/nurse practitioner/physician assistant — 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"/> 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.						
33a. SIGNATURE AND TITLE OF CERTIFIER Lori B. Shue RN				33b. LICENSE NUMBER		
33c. DATE SIGNED (Month/Day/Year) 8-10-2020						
33d. NAME AND ADDRESS OF CERTIFIER (Print legibly) Lori B. Shue, RN- 301 Yadkin Street Albemarle, NC 28801				36. DATE REGISTERED BY STATE		
34. FOR LOCAL REGISTRAR (Name) David Jenkins WE		35. DATE FILED (Month/Day/Year) AUG 27 2020				
DATE CORRECTED (Mo/Day/Yr)		ITEM(S) CORRECTED:				
DATE AMENDED (Mo/Day/Yr)		ITEM(S) AMENDED:				

BURIAL/CREMATION PERMIT
 Medical Examiner: Authorization for Disposition/Transportation
 After the medical examiner completes and signs this burial
 transit permit/cremation authorization, it constitutes authority for
 burial, cremation, transportation or removal from the state.
 A copy of this form serves as a Burial/Cremation Permit.