

BUREAU of VITAL STATISTICS

CERTIFICATION OF DEATH

STATE FILE NUMBER: [REDACTED]

DATE ISSUED: [REDACTED]

DECEDENT INFORMATION

DATE FILED: [REDACTED]

NAME: WILLIAM LEONARD FIZER

DATE OF DEATH: [REDACTED]

SEX: [REDACTED]

SSN: [REDACTED]

AGE: [REDACTED]

DATE OF BIRTH: [REDACTED]

BIRTHPLACE: [REDACTED]

PLACE OF DEATH: [REDACTED]

FACILITY NAME OR STREET ADDRESS: [REDACTED]

LOCATION OF DEATH: [REDACTED]

RESIDENCE: [REDACTED]

COUNTY: COLUMBIA

OCCUPATION, INDUSTRY: [REDACTED]

EDUCATION: [REDACTED]

EVER IN U.S. ARMED FORCES? [REDACTED]

HISPANIC OR HAITIAN ORIGIN? [REDACTED]

RACE: [REDACTED]

SURVIVING SPOUSE / PARENT NAME INFORMATION

(NAME PRIOR TO FIRST MARRIAGE, IF APPLICABLE)

MARITAL STATUS: [REDACTED]

SURVIVING SPOUSE NAME: [REDACTED]

FATHER'S/PARENT'S NAME: [REDACTED]

MOTHER'S/PARENT'S NAME: [REDACTED]

INFORMANT, FUNERAL FACILITY AND PLACE OF DISPOSITION INFORMATION

INFORMANT'S NAME: ZETTIA LOIS FIZER

RELATIONSHIP TO DECEDENT: [REDACTED]

INFORMANT'S ADDRESS: [REDACTED]

FUNERAL DIRECTOR/LICENSE NUMBER: [REDACTED]

FUNERAL FACILITY: [REDACTED]

METHOD OF DISPOSITION: [REDACTED]

PLACE OF DISPOSITION: [REDACTED]

CERTIFIER INFORMATION

TYPE OF CERTIFIER: [REDACTED]

MEDICAL EXAMINER CASE NUMBER: [REDACTED]

TIME OF DEATH (24 HOUR): [REDACTED]

DATE CERTIFIED: [REDACTED]

CERTIFIER'S NAME: [REDACTED]

CERTIFIER'S LICENSE NUMBER: [REDACTED]

NAME OF ATTENDING PRACTITIONER (IF OTHER THAN CERTIFIER): [REDACTED]

CAUSE OF DEATH AND INJURY INFORMATION

MANNER OF DEATH: [REDACTED]

CAUSE OF DEATH - PART I - AND APPROXIMATE INTERVAL: [REDACTED]

a. [REDACTED]

UNKNOWN

b.

c.

d.

PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I:

AUTOPSY PERFORMED? [REDACTED]

AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH?

DATE OF SURGERY:

DID TOBACCO USE CONTRIBUTE TO DEATH? [REDACTED]

REASON FOR SURGERY:

PREGNANCY INFORMATION: [REDACTED]

DATE OF INJURY: [REDACTED]

TIME OF INJURY (24 HOUR):

INJURY AT WORK?

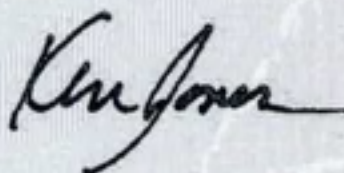
LOCATION OF INJURY:

DESCRIBE HOW INJURY OCCURRED:

PLACE OF INJURY:

IF TRANSPORTATION INJURY, STATUS OF DECEDENT:

TYPE OF VEHICLE:



, STATE REGISTRAR

REQ: [REDACTED]

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.

WARNING:

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH WATERMARKS OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARKS. THE DOCUMENT FACE CONTAINS A MULTICOLORED BACKGROUND, GOLD EMBOSSED SEAL, AND THERMOCHROMIC FL. THE BACK CONTAINS SPECIAL LINES WITH TEXT. THIS DOCUMENT WILL NOT PRODUCE A COLOR COPY.

DH FORM 1947 (08/01/2022)

CERTIFICATION OF VITAL RECORD



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