DATE FILED THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Certificate No.

☐ New
☒ Corr/Amend
☐ Replacement

DOHMH USE ONLY: BOR, INST, MANNER, RESIDENCE, CODE, BP, LDIS, H, ANC, NH, ANC, ICD, AUT

THIS CERTIFICATE NOT VALID UNLESS FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. DECEDENT'S LEGAL NAME: Sun-Ming Sheu (First, Middle, Last)

MEDICAL CERTIFICATE OF DEATH (To be filled in by the OCME)

Place Of Death — 2a. New York City 2b. Borough: Queens

2c. Type of Place: 1 ☒ Hospital Inpatient 2 ☐ Emergency Dept./Outpatient 3 ☐ Dead on Arrival 4 ☐ Nursing Home/Long Term Care Facility 5 ☐ Hospice Facility 6 ☐ Decedent's Residence 7 ☐ Other Specify

2d. Any Hospice care in last 30 days: 1 ☐ Yes 2 ☒ No 3 ☐ Unknown

2e. Name of hospital or other facility (if not facility, street address): New York Hospital Medical Center of Queens

Date and Time of Death or Found Dead: 3a. (Month) June (Day) 26 (Year-yyyy) 2010 3b. Time 08:13 ☐ AM ☒ PM

4. Sex: Male

5. OCME Case No. [redacted]

6. CAUSE OF DEATH

PART I
a. Immediate cause: Blunt Force Trauma To Head With Skull Fractures And Brain Injuries — Approximate interval onset to death: -
b. Due to or as a consequence of: *** — ***
c. 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. Include operation information. ***

7a. Injury Date (mm dd yyyy): Unknown
7b. Time: *** ☐ AM ☒ PM
7c. At Work: 1 ☐ Yes 2 ☐ No
7d. Place of Injury – At home, factory, street, etc.: Unknown
7e. Location: Unknown,,
7f. How Injury Occurred: Unknown
7g. If Transportation Injury Specify: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other Specify

8. Manner of Death: ☐ Pending further study ☐ Natural ☐ Homicide ☐ Accident ☐ Suicide ☒ Undetermined

9. Autopsy: ☒ Yes ☐ No Autopsy Pursuant to Law ☐ No Autopsy

10. On the basis of examination and/or investigation, in my opinion, death occurred due to the causes and manner as stated.
Certifier Signature: *Michael Greenberg* — Signature Electronically Authenticated — D.O. M.D. Date JUL-01-2010
Certifier Name (Print): Michael Greenberg — Medical Examiner
(Medical Investigator) (Deputy Chief) (Chief) (Medical Examiner)

PERSONAL PARTICULARS (To be filled in by Funeral Director or, in case of City Burial, by OCME)

11a. Usual Residence State [redacted] 11b. County [redacted] 11c. City or Town [redacted] 11d. Street and Number [redacted] Apt. No. ZIP Code
11e. Inside City Limits? 1 ☒ Yes 2 ☐ No

12. Date of Birth (Month) (Day) (Year-yyyy) [redacted]
13. Age at last birthday (years) [redacted] — Under 1 Year: Months, Days — Under 1 Day: Hours, Minutes
14. Social Security No. [redacted]

15a. Usual Occupation (Type of work done during most of working life. Do not use "retired") [redacted]
15b. Kind of business or industry [redacted]
16. Aliases or AKAs: *** ***

17. Birthplace (City & State or Foreign Country) [redacted]

18. Education (Check the box that best describes the highest degree or level of school completed at the time of death)
1 ☐ 8th grade or less; none
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (e.g., AA, AS)
6 ☒ Bachelor's degree (e.g., BA, AB, BS)
7 ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
8 ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

19. Ever in U.S. Armed Forces? [redacted]
20. Marital/Partnership Status at time of death [redacted]
21. Surviving Spouse's/Partner's Name (If wife, name prior to first marriage)(First, Middle, Last): *** ***

22. Father's Name (First, Middle, Last) [redacted]
23. Mother's Maiden Name (Prior to first marriage) (First, Middle, Last)

24a. Informant's Name [redacted]
24b. Relationship to Decedent [redacted]
24c. Address (Street and Number Apt. No. City & State ZIP Code) [redacted] ***

25a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Entombment 4 ☐ City Cemetery 5 ☐ Other Specify
25b. Place of Disposition (Name of cemetery, crematory, other place) [redacted]
25c. Location of Disposition (City & State or Foreign Country) [redacted]
25d. Date of Disposition (mm dd yyyy) [redacted]

26a. Funeral Establishment [redacted]
26b. Address (Street and Number City & State ZIP Code) [redacted]

VR 16 (Rev. 01/09)

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S SUPPLEMENTARY REPORT

VR 16 (Rev. 01/09)

Certificate No.

To be filled in by **FUNERAL DIRECTOR** or, in case of City Burial, by OCME

27. Ancestry (Check one box and specify)
☐ Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify
☒ NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) Specify: Chinese

28. Race as defined by the U.S. Census (Check one or more to indicate what the decedent considered himself or herself to be)
01 ☐ White 02 ☐ Black or African American
03 ☐ American Indian or Alaska Native (Name of enrolled or principal tribe)
04 ☐ Asian Indian 05 ☒ Chinese
06 ☐ Filipino 07 ☐ Japanese
08 ☐ Korean 09 ☐ Vietnamese
10 ☐ Other Asian–Specify
11 ☐ Native Hawaiian 12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander–Specify
15 ☐ Other–Specify

Sun-Ming Sheu
DECEDENT'S LEGAL NAME (Type or Print)

29a. If Female
1 ☐ Not pregnant within 1 year of death
2 ☐ Pregnant at time of death
3 ☐ Not pregnant at death, but pregnant within 42 days of death
4 ☐ Not pregnant at death, but pregnant 43 days to 1 year before death
5 ☐ Unknown if pregnant within 1 year of death

29b. If pregnant within one year of death, outcome of pregnancy
1 ☐ Live Birth
2 ☐ Spontaneous Termination / Ectopic Pregnancy
3 ☐ Induced Termination 4 ☐ None

29c. Date of Outcome: mm dd yyyy

30. Did tobacco use contribute to death? [redacted]
31. For infant under one year: Name and address of hospital or other place of birth

Cleared For Cremation If Family Requests

Michael Greenberg
M.E. Signature

I certify that I personally examined the body on JUL-01-2010 (Date) at Queens Medical Examiner Office (Location)
SIGNATURE: *Michael Greenberg*
(Medical Investigator) (Deputy Chief) (Chief) (Medical Examiner)

or

I did not personally examine the body after death.
SIGNATURE: ______
(Deputy Chief) (Chief) (Medical Examiner)

System Case Id 543100