

4140

# CERTIFICATE OF DEATH

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT  
VITAL RECORDS

008812

BIRTH NO. \_\_\_\_\_

STATE FILE NO. \_\_\_\_\_

1. DECEASED—NAME FIRST: Marie MIDDLE: Gegumis LAST: Gegumis			2. DATE OF DEATH (MONTH, DAY, YEAR) 12-17-87			
3a. AGE—LAST BIRTHDAY (YEARS) 86	3b. MOB.	3c. DAYS	4. DATE OF BIRTH (MONTH, DAY, YEAR) 7-27-1901	5a. RACE WHITE, BLACK, AMERICAN INDIAN, ETC. (SPECIFY) White	5b. ORIGIN OR DESCENT—ITALIAN, MEXICAN GERMAN, ETC. (SPECIFY) American	6. SEX Female
7a. COUNTY OF DEATH Shelby	7b. CITY, TOWN OR LOCATION Memphis	7c. INSIDE CITY LIMITS (SPECIFY YES OR NO) Yes	7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, SPECIFY PRIVATE RESIDENCE, BUSINESS, STREET, ETC.) St Francis Hospital		7e. IF HOSP. OR INST. Indicate OOA, OP/Emar. Pm., Instatkm (Specify)	
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY) W. VA.	9. CITIZEN OF WHAT COUNTRY USA	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) Widowed		11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)		
12a. SOCIAL SECURITY NUMBER (IF NONE, SPECIFY) 412-03-9870	12b. SERVICE IN ARMED FORCES (SPECIFY WAR OR DATES OF SERVICE) No	13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVER IF RETIRED) Homemaker		13b. KIND OF BUSINESS OR INDUSTRY Home		
14a. RESIDENCE—STATE TN	14b. COUNTY Shelby	14c. CITY, TOWN, OR LOCATION Memphis	14d. STREET AND NUMBER 4708 Given	14e. INSIDE CITY LIMITS (SPECIFY YES OR NO) Yes	14f. CENSUS TRACT NO. 098-	
15. FATHER—NAME Joseph Sodaro		16. MOTHER—MAIDEN NAME Elizabeth Bosie		17. INFORMANT—NAME Catherine Ellis		MAILING ADDRESS Same
18a. BURIAL, CREMATION, REMOVAL, OTHER (SPECIFY) Burial	18b. DATE (MONTH, DAY, YEAR) 12-19-87	18c. CEMETERY OR CREMATORY—NAME Memorial Park	18d. LOCATION Memphis, Tn			
19a. FUNERAL DIRECTOR (SIGNATURE) Lynn Gauthier		19b. LICENSE NO. 3900	19c. EMBALMER (SIGNATURE) William T. Young		19d. LICENSE NO. 2968	
20. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) Memphis Funeral Home, 5599 Poplar, Memphis, Tn			21. REGISTRAR—SIGNATURE June Baugh Deputy		21b. DATE RECEIVED BY LOCAL REGISTRAR DEC 23 1987	
22a. PHYSICIAN—CERTIFY THAT THE DEATH OCCURRED AT THE PLACE, ON THE DATE, AND DUE TO THE CAUSE(S) STATED.			22b. SIGNATURE <i>[Signature]</i>		22c. DEGREE M.D.	
23a. MEDICAL EXAMINER—ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.			23b. SIGNATURE <i>[Signature]</i>		23c. TITLE M.D.	
24a. CERTIFIER—NAME (TYPE OR PRINT) Patrick J. Muranylo			24b. MAILING ADDRESS 899 Madison	24c. STREET OR R.F.D. NO. 838M	24d. CITY OR TOWN Memphis	
24e. STATE Tn			24f. ZIP 38103			
25. PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))						
IMMEDIATE CAUSE (a) Acute Bronch. pneumonia due to Pseudomonas Aeruginosa 2 wks						
DUE TO, OR AS A CONSEQUENCE OF: (b) AS HD to Chr. CHF						
DUE TO, OR AS A CONSEQUENCE OF: (c)						
26. PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)					AUTOPSY (YES OR NO) 26.	
27a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY)		27b. DATE OF INJURY (MONTH, DAY, YEAR)	27c. HOUR M.	27d. DESCRIBE HOW INJURY OCCURRED		
27e. INJURY AT WORK (SPECIFY YES OR NO)		27f. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG, ETC. (SPECIFY)	27g. LOCATION	27h. STREET OR R.F.D. NO.	27i. CITY OR TOWN	
					27j. STATE	

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col. Scanned 6/7

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129193

UJO 000000 LOCAL FILE NUMBER

DIVISION OF VITAL STATISTICS  
PHYSICIAN'S CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT - NAME FIRST MIDDLE LAST <b>Anna B Sodaro</b>			SEX <b>FEMALE</b>	DATE OF DEATH (Mo., Day, Yr.) <b>8/24/86</b>
RACE (Specify Yes or No) <b>WHITE</b>	AGE - Last Birthday (Yr.) <b>83</b>	UNDER 1 YEAR MOS. DATES	UNDER 1 DAY HOURS MINS	DATE OF BIRTH (Mo., Day, Yr.) <b>7/13/03</b>
CITY, TOWN OR LOCATION OF DEATH <b>Charleston</b>		HOSPITAL OR OTHER INSTITUTION - Name, if not in either, give street and number <b>Capital City New Home</b>		8 MOST OR MOST IMPROPER OF Emer. Res. Incident (Specify) <b>Trust</b>
STATE OF BIRTH (If not in U.S.A., name country) <b>WV</b>	CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	MARRIED NEVER MARRIED WIDOWED, DIVORCED (Specify)	SURVIVING SPOUSE (If female, give maiden name) <b>None</b>	
SOCIAL SECURITY NUMBER <b>235-84-2010</b>		14a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Never Worked</b>	KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
RESIDENCE - STATE <b>WV</b>	COUNTY <b>KANAWHA</b>	CITY, TOWN OR LOCATION <b>Charleston</b>	STREET AND NUMBER <b>162 Dutch Ed Plac.</b>	15b WAS DECEASED EVER IN U.S. ARMED FORCES? (Specify Yes or No) <b>No</b>
FATHER - NAME FIRST MIDDLE LAST <b>Joseph Sodaro</b>	MOTHER MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Bossie</b>			
INFORMANT - NAME (Type or Print) <b>Bartlett Burnett Cox</b>		MAILING ADDRESS <b>513 TENN. AVE., CHARLESTON WV</b>	STREET OR R.F.D. NO. CITY OR TOWN STATE	
MANNER OF DEATH (Specify) <b>BURIAL</b>		CEMETERY OR CREMATORY - NAME <b>Mt. Olivet Cemetery</b>	LOCATION <b>CHARLESTON, WV</b>	CITY OR TOWN STATE
FUNERAL DIRECTION LICENSEE Or Person Acting As Such (Specify) <b>Barbara Wilson</b>		NAME OF FACILITY <b>Bartlett-Burnette-Cox</b>	ADDRESS OF FACILITY <b>CHARLESTON, WV</b>	
21a (Signature) <b>Kenneth L Clark</b>		DATE SIGNED (Mo., Day, Yr.) <b>8-26-86</b>	HOUR OF DEATH <b>7:00 A</b>	
21d NAME AND ADDRESS OF CERTIFIER (Type or Print) <b>Kenneth L Clark, M.D. 3100 MacCorkle Ave. S.E. Charleston, WV 25304</b>		DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) <b>8-29-86</b>		
22a (Signature) <b>Sandra King</b>		72b		
IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) <b>Lymphocytic leukemia</b>		Interval between onset and death		
(a) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death <b>10 minutes</b>		
(b) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death		
(c) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death		
OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART 1 (a) <b>Heart minute</b>		AUTOPSY (Specify Yes or No) <b>No</b>	WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No) <b>No</b>	
26a PRESENT (Specify Yes or No) <b>No</b>	DATE OF INJURY (Mo., Day, Yr.) <b>N/A</b>	HOUR OF INJURY <b>N/A</b>	DESCRIBE HOW INJURY OCCURRED <b>N/A</b>	
26b YES, MOVED BY MED EXAMINER	26b PLACE OF INJURY - At home, farm, street, factory, office building, etc (Specify) <b>N/A</b>	26c N/A	26d LOCATION <b>N/A</b>	STREET OR R.F.D. NO. CITY OR TOWN STATE
26a NO	26a PLACE OF INJURY - At home, farm, street, factory, office building, etc (Specify) <b>N/A</b>	26c N/A	26d LOCATION <b>N/A</b>	STREET OR R.F.D. NO. CITY OR TOWN STATE

I, VERA J. McCORMICK do hereby certify that this is a true copy from the record.  
Teste: VERA J. McCORMICK  
Kanawha County Commission

Date 8/18/86 By Sandra King  
Clerk

EXHIBIT "2"  
File No.: PRC120005221 - E/O Joseph N Sodaro  
Notice of Filing Heirship Documentation - Group 1

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## Social Security Death Index

Name: **Philip Sodaro**  
SSN: 235-01-3587  
Last Residence: 25302 Charleston, Kanawha, West Virginia, United States of America  
Born: 10 Jan 1905  
Died: Dec 1986  
State (Year) SSN issued: West Virginia (Before 1951)

**Source Citation:** Number: 235-01-3587; Issue State: West Virginia; Issue Date: Before 1951.

**Source Information:**

Ancestry.com. *Social Security Death Index* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2011.  
Original data: Social Security Administration. *Social Security Death Index, Master File*. Social Security Administration.

**Description:**

The Social Security Administration Death Master File contains information on millions of deceased individuals with United States social security numbers whose deaths were reported to the Social Security Administration. Birth years for the individuals listed range from 1875 to last year. Information in these records includes name, birth date, death date, and last known residence.

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OFFICE of VITAL STATISTICS

CERTIFIED COPY

**CERTIFICATE OF DEATH  
FLORIDA**

1 DECEDENT'S NAME FIRST **Marguerite** MIDDLE **S.** LAST **Rhodes** 2 SEX **Female**

3 DATE OF DEATH (Month, Day, Year) **September 07, 1997** 4 SOCIAL SECURITY NUMBER **235-03-5461** 5a AGE Last Birthday (years) **91** 5b UNDER 1 YEAR Months **0** Days **0** 5c UNDER 1 Day Hours **0** Minutes **0**

6 DATE OF BIRTH (Month, Day, Year) **May 02, 1906** 7 BIRTHPLACE (City and State or Foreign Country) **Charleston, West Virginia** 8 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) **NO**

9a PLACE OF DEATH (Check only one - see instructions on other side) **HOSPITAL**  Inpatient  ER/Outpatient  DOA  OTHER  Nursing Home  Residence  Other (Specify) **9b INSIDE CITY LIMITS? (Yes or No)** **Yes**

9c FACILITY NAME (If not institution, give street and number) **Broward General Medical Center/Hospice** 9d CITY, TOWN, OR LOCATION OF DEATH **Fort Lauderdale** 9e COUNTY OF DEATH **Broward**

10a DECEDENT'S USUAL OCCUPATION **Homemaker** 10b KIND OF BUSINESS/INDUSTRY **Own Home** 11 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) **Widowed** 12 SURVIVING SPOUSE (If wife, give maiden name)

13a RESIDENCE - STATE **Florida** 13b COUNTY **Broward** 13c CITY, TOWN, OR LOCATION **Fort Lauderdale** 13d STREET AND NUMBER **1201 SE Eighth Street**

13e INSIDE CITY LIMITS? (Yes or No) **Yes** 13f ZIP CODE **33316** 14 WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.)  No  Yes Specify **White** 15 RACE - American Indian, Black, White, etc. Specify **White** 16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (K-12) **12** College (1-4 or 5+)

17 FATHER'S NAME (First, Middle, Last) **Joseph Sodaro** 18 MOTHER'S NAME (First, Middle, Maiden Surname) **Rosa Bossic**

19a INFORMANT'S NAME (Type/Print) **Juanita Chaffin** 19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1201 SE Eighth Street Fort Lauderdale, FL 33316**

20a METHOD OF DISPOSITION  Burial  Cremation  Removal from State  Donation  Other (Specify) **20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)** **Queen of Heaven Cemetery** **20c LOCATION - City or Town, State** **North Lauderdale Florida**

21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH *[Signature]* 21b LICENSE NUMBER (of licensee) **5664** 21c NAME AND ADDRESS OF FACILITY **Fred Hunter's Fort Lauderdale Home 718 S. Federal Hwy. Fort Lauderdale, FL, 33316**

22a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated (Signature and Title) *[Signature]* 22b DATE SIGNED (Mo, Day, Yr) **9/08/97** 22c HOUR OF DEATH **-4:20 A** 23a 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 as stated (Signature and Title) *[Signature]* 23b DATE SIGNED (Mo, Day, Yr) **9/9/97** 23c HOUR OF DEATH **M**

22d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) **M** 23d MEDICAL EXAMINER'S CASE # **M**

24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) **Gabriel Valle, M.D., 4800 N. 20th Terr. #115, Ft. Lauderdale, Florida**

25a SUBREGISTRAR - SIGNATURE AND DATE *[Signature]* **9/9/97** 25b LOCAL REGISTRAR - SIGNATURE *[Signature]* 25c DATE REGISTERED **SEP 10 1997**

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

THIS IS A CERTIFIED TRUE

OFFICE

SEP 29 1997

EXHIBIT "4"  
File No.: PRC120005221 - E/O Joseph N Sodaro  
Notice of Filing Heirship Documentation - Group 1

BY *Doris Owens, Chief Deputy Registrar* State Registrar

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THIS DOCUMENT HAS A LIGHT BACKGROUND ON TRUE WATERMARKED PAPER. HOLD TO LIGHT TO VERIFY FLORIDA WATERMARK  
OFFICE of VITAL STATISTICS

2007 163413

FLORIDA CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last, Suffix) <b>Frances Morehead</b>		2. SEX <b>Female</b>	
3. DATE OF BIRTH (Month, Day, Year) <b>May 12, 1908</b>		4a. AGE-Last Birthday (Year) <b>99</b>	
4b. UNDER 1 YEAR Months: _____ Days: _____		4c. UNDER 1 DAY Hours: _____ Minutes: _____	
5. DATE OF DEATH (Month, Day, Year) <b>December 26, 2007</b>			
6. SOCIAL SECURITY NUMBER <b>233-16-3455</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Charleston, West Virginia</b>	
8. COUNTY OF DEATH <b>Broward</b>			
9. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival NON-HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
10. FACILITY NAME (If not institution, give street address) <b>3485 NW 30 Street</b>		11a. CITY, TOWN, OR LOCATION OF DEATH <b>Lauderdale Lakes</b>	
		11b. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
12. MARITAL STATUS (Specify) <input type="checkbox"/> Married <input type="checkbox"/> Married, but Separated <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married			
13. SURVIVING SPOUSE'S NAME (If wife, give maiden name)			
14a. RESIDENCE - STATE <b>Florida</b>		14b. COUNTY <b>Broward</b>	
14c. CITY, TOWN, OR LOCATION <b>Lauderdale Lakes</b>			
14d. STREET ADDRESS <b>3485 NW 30 Street</b>		14e. APT. NO. <b>33311</b>	
14f. ZIP CODE <b>33311</b>		14g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. Do not use "Retired") <b>Saleslady</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Retail</b>	
16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Specify tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Is. (Specify) <input type="checkbox"/> Other (Specify)			
17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) <input checked="" type="checkbox"/> Yes (If Yes, specify) <input type="checkbox"/> No <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central/South American <input type="checkbox"/> Haitian <input type="checkbox"/> Other Hispanic (Specify)			
18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.) <input type="checkbox"/> 8th or less <input type="checkbox"/> High school but no diploma <input checked="" type="checkbox"/> High school diploma or GED <input type="checkbox"/> College but no degree <input type="checkbox"/> College degree (Specify): <input type="checkbox"/> Associate <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate			19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
20. FATHER'S NAME (First, Middle, Last, Suffix) <b>Joseph Sodaro</b>		21. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Bossie</b>	
22a. INFORMANT'S NAME <b>Dolores R. Anania</b>		22b. RELATIONSHIP TO DECEDENT <b>Daughter</b>	
23a. INFORMANT'S MAILING - STATE <b>Florida</b>			
23b. CITY OR TOWN <b>Fort Lauderdale</b>		23c. STREET ADDRESS <b>4601 NE 23 Avenue</b>	
		23d. ZIP CODE <b>33308</b>	
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Queen of Heaven Cemetery</b>		25a. LOCATION - STATE <b>Florida</b>	
		25b. LOCATION - CITY OR TOWN <b>North Lauderdale</b>	
26a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)			
26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? <input type="checkbox"/> Yes <input type="checkbox"/> No		27a. LICENSE NUMBER (of Licensee) <b>F044964</b>	
		27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Mark H. Van...</i>	
28. NAME OF FUNERAL FACILITY <b>Fred Hunter Funeral Home</b>		29a. FACILITY'S MAILING - STATE <b>Florida</b>	
29b. CITY OR TOWN <b>Fort Lauderdale</b>		29c. STREET ADDRESS <b>718 S. Federal Highway</b>	
		29d. ZIP CODE <b>33316</b>	
30. CERTIFIER: <input checked="" type="checkbox"/> 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. (Check one) <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated.			
31a. (Signature and Title for Certifier) <i>[Signature]</i> <b>PHYSICIAN'S SIGNATURE</b>		31b. DATE SIGNED (mm/dd/yyyy) <b>12/28/07</b>	
32. TIME OF DEATH (24 hr.) <b>1935</b>		33. MEDICAL EXAMINER'S CASE NUMBER	
34a. LICENSE NUMBER (of Certifier) <b>ME34270</b>		34b. CERTIFIER'S NAME <b>Octavio Prieto, MD</b>	
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)			
36a. CERTIFIERS - STATE <b>Florida</b>		36b. CITY OR TOWN <b>Plantation</b>	
36c. STREET ADDRESS <b>4301 W Broward Blvd</b>		36d. ZIP CODE	
37. SUBREGISTRAR - Signature and Date <i>[Signature]</i>		38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.) <b>DEC 31 2007</b>	

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Filed by Kemp & Assoc (Atty. Cohen) ExH. 10

*[Signature]*, State Registrar

Date Issued: FEB 18 2013

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CERTIFICATION OF VITAL RECORD

HEALTH

EXHIBIT "5"  
File No.: PRC120005221 - E/O Joseph N Sodaro  
Notice of Filing Heirship Documentation - Group 1

DH FOJ

WEST VIRGINIA STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS  
PHYSICIAN'S CERTIFICATE OF DEATH

016794

DECEASED—NAME		FIRST	MIDDLE	LAST	SEX	COUNTY OF DEATH	DATE OF DEATH (Mo., Day, Yr.)
John Ernest Sodaro		John	Ernest	Sodaro	Male	Kanawha	11-10-82
RACE (e.g., White, Black, American Indian, etc.) (Specify)		AGE—Last Birthday	UNDER 1 YEAR	UNDER 1 DAY	DATE OF BIRTH (Mo., Day, Yr.)		
White		49 1/2	MOS. DAYS	HOURS	3-25-1910		
CITY, TOWN OR LOCATION OF DEATH		HOSPITAL OR OTHER INSTITUTION—Name (if not in either, give street and number)					
Charleston		St. Francis Hospital					
STATE OF BIRTH (if not in U.S., name country)		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)					
WV		Married					
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (One kind of work done during most of working life, even if retired)					
235-01-3627		Employee					
RESIDENCE—STATE		CITY, TOWN OR LOCATION		STREET AND NUMBER		KIND OF BUSINESS OR INDUSTRY	
WV		Chas.		Rt. 5 Box 250		Workmens Comp.	
FATHER—NAME		MOTHER—MAIDEN NAME					
Joseph Sodaro		Chas. Sodaro					
INFORMANT—NAME (Type or print)		MAILING ADDRESS		STREET OR R.F.D. NO.		CITY OR TOWN	
George F. Sodaro		Rt. 5 Box 249D		Charleston		WV	
BURIAL, CREATION, REMOVAL, OTHER (Specify)		CEMETERY OR CREATOR—NAME		LOCATION		CITY OR TOWN	
Burial		Elk Hills Memorial Park		Big Chimney		WV	
FUNERAL SERVICE (Licensee or Person Acting As Such) (Signature)		NAME OF FACILITY		ADDRESS OF FACILITY		CITY OR TOWN	
Myers Funeral Home		Myers Funeral Home		100 Verna Dr.		Elkview, WV	
To the best of my knowledge, death occurred at the date and place and due to the cause(s) stated.		NAME OF ATTENDING PHYSICIAN (If OTHER THAN REGISTRAR, (Type or Print))		DATE SIGNED (Mo., Day, Yr.)		HOUR OF DEATH	
George F. Sodaro		George F. Sodaro MD.		11-10-82		12:30	
NAME AND ADDRESS OF REGISTRAR		NAME AND ADDRESS OF CERTIFYING PHYSICIAN					
George F. Sodaro MD. 17-110 Woodbine Ave. Charleston, WV		George F. Sodaro MD. 25302					
IMMEDIATE CAUSE		INTERVAL BETWEEN ONSET AND DEATH					
Broncho Pneumonia, Bilateral		2 days					
DUE TO, OR AS A CONSEQUENCE OF:		INTERVAL BETWEEN ONSET AND DEATH					
Carcinoma, Urinary Bladder, Stage D2		11 months					
DUE TO, OR AS A CONSEQUENCE OF:		INTERVAL BETWEEN ONSET AND DEATH					
Obesity, Exogenous							
OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)		AUTOPSY (Specify Yes or No)		WAS CASE REFERRED TO MEDICAL EXAMINER OR CONDONER (Specify Yes or No)			
		No		No			
ACCIDENT (Specify Yes or No)		DATE OF INJURY (Mo., Day, Yr.)		HOUR OF INJURY		DESCRIBE HOW INJURY OCCURRED	
INJURY AT WORK (Specify Yes or No)		PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		LOCATION		STREET OR R.F.D. NO.	

ORIGINAL

EXHIBIT "6"  
File No.: PRC120005221 - E/O Joseph N Sodaro  
Notice of Filing Heirship Documentation - Group 1

copy - scanned 1/7/13

Filed by ARB (Cathy Livoti)

United States of America

State of West Virginia



County of Kanawha, ss:

Birth Certificate

I, Vera J. McCormick, Clerk of the Kanawha County, WV County Commission aforesaid, and as such, custodian of the records of Births, hereby certify that as reference to Birth Book 3 Page 286 of my office will show.

Child Name: **GEORGE E SODARO**

Mother Information

Father Information

Maiden: **ROSE SODARO**

Name: **JOE SODARO**

Birth Record Information

Birth Date: **April 25, 1912**

Date Recorded: **\*\*\* NOT A DATE \*\*\* \*\* NOT A DATE \*\*\*, \*\*\* NOT A DATE \*\*\***

Birth Place: **CHARLESTON**

Birth Sex: **MALE**

Certified By: **JOE SODARO, FATHER**

In Witness Whereof, I have hereunto set my hand and affixed the Seal of the said commission, this 18th day of June A.D., 2013 and in the 149th year of said state.

Vera J. McCormick, Clerk  
County Commission of Kanawha County, WV  
By [Signature] Deputy

EXHIBIT "7"  
File No.: PRC120005221 - E/O Joseph N Sodaro  
Notice of Filing Heirship Documentation - Group 1

**WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES  
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION 015506  
PHYSICIANS / MEDICAL EXAMINER'S CERTIFICATE OF DEATH 017671  
ROOM 185, 350 CAPITOL STREET, CHARLESTON, WV 25301**

STATE FILE NUMBER

TYPE/PRIENT IN PERMANENT BLACK INK

1. DECEDENT'S NAME (First, Middle, Last) <b>BERNARD PAUL SODARO</b>				2. SEX <b>M</b>	3. DATE OF DEATH (Month, Day, Year) <b>11-16-2007</b>
4. SOCIAL SECURITY NUMBER <b>233-10-6778</b>	5a. AGE-Last Birthday (Years) <b>92</b>	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Month, Day, Year) <b>01-18-1915</b>	7. BIRTHPLACE (City and State or Country) <b>Charleston, WV</b>
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) <b>No</b>		9a. PLACE OF DEATH (Check only one; see instructions on other side) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): _____			
9b. FACILITY NAME (If not institution, give street and number) <b>Heartland Nursing Home</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>Charleston</b>		9d. COUNTY OF DEATH <b>Kanawha</b>
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) <b>Widowed</b>	11. SURVIVING SPOUSE (If wife, give maiden name) _____	12. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Business Owner</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Body Shop</b>	
13a. RESIDENCE—STATE <b>WV</b>	13b. COUNTY <b>Kanawha</b>	13c. CITY, TOWN, OR LOCATION <b>Charleston</b>		13d. STREET AND NUMBER <b>113 Park Avenue</b>	
14a. INSIDE CITY LIMITS? (Yes or no) <b>Yes</b>	14b. ZIP CODE <b>25302</b>	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____		15. RACE—American Indian, Black, White, etc (Specify) <b>White</b>	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (K-12): <b>1-12</b> College (13-16): _____
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Sodaro</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Bossie</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Roseann Sodaro French</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>154 Whispering Woods Rd., Charleston, WV 25304</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify): _____		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Mt. Olivet Cemetery</b>		20c. LOCATION—City or Town, State <b>Charleston, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Linda J. Wilson</i>			22. NAME AND ADDRESS OF FACILITY <b>Barlow-Bonsall Funeral Home 1118 Virginia St., East Charleston, WV 25301</b>		
23a. Complete items 23a-b only when certifying physician is not available at time of death to certify cause of death		23b. To the best of my knowledge, death occurred at the time, date, and place stated		23c. DATE SIGNED (Month, Day, Year) <b>11/21/07</b>	
24. TIME OF DEATH <b>11:10 p.m.</b>		25. DATE PRONOUNCED DEAD (Month, Day, Year) <b>11-16-07</b>		26. WAS CASE REFERRED TO MEDICAL EXAMINER/CONSUMER? (Yes or no) <b>No</b>	
27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate interval between Onset and Death)					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIORESPIRATORY ARREST</b>					
a. DUE TO (OR AS A CONSEQUENCE OF) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>					
b. DUE TO (OR AS A CONSEQUENCE OF) <b>DIABETES</b>					
c. DUE TO (OR AS A CONSEQUENCE OF) <b>HYPERTENSION</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I					
28. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		29a. DATE OF INJURY (Month, Day, Year)	29b. TIME OF INJURY	29c. INJURY AT WORK? (Yes or No)	29d. DESCRIBE HOW INJURY OCCURRED
31a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER/CONSUMER On the basis of appropriate investigation, death occurred at the time, date, and place and due to the cause(s) and manner as stated.		31b. SIGNATURE AND TITLE OF CERTIFIER <i>Vera J. McCormick</i> <b>Vera J. McCormick, Clerk</b>		31c. DATE SIGNED (Month, Day, Year) <b>11/21/07</b>	
32. NAME AND ADDRESS OF REGISTRAR (Print name and address of person who filed this certificate) <b>Vera J. McCormick, 105 736 12/23/2007 10:25:31 AM Vera J. McCormick County Clerk Kanawha County, WV</b>				33. REGISTRAR'S SIGNATURE (Print name and address of person who filed this certificate) <i>Vera J. McCormick</i> <b>Vera J. McCormick, Clerk</b>	
34. DATE FILED (Month, Day, Year) <b>NOV 21 2007</b>					

Form VS-002 (Rev. 10/01)

**WARNING:** THIS DOCUMENT IS SECURITY PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.

Date: **11/16/07** By: *[Signature]* **SALEMAN**