

COPY 1
STATE COPY

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER FOR HEALTH STATISTICS — NC VITAL RECORDS

NOV 20 2007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

063927

Registration District No. 045-00 Local No. 1082

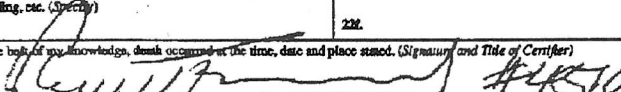
10-888

MEDICAL EXAMINER: After you've initiated the certificate of death, give certificate to funeral director when the body is released. If the cause of death is pending, the supplemental report of cause of death (Form VSb-A) when additional information has been obtained. FUNERAL DIRECTOR: Copies 1 & 2 must be completed and filed with a local registrar within 5 days after death. Copy 3, when signed by medical examiner, is your authorization for final disposition.

DECEDENT	1. MISCHA AUGUST SCHMIDT		SEX 2. M	DATE OF DEATH (Month, Day, Year) 3. OCTOBER 29, 2007	
	SOCIAL SECURITY NUMBER 4. 264-57-3205	AGE—Last Birthday (Years) 5a. 42	UNDER 1 YEAR Months Days 5b.	UNDER 1 DAY Hours Minutes 5c.	DATE OF BIRTH (Month, Day, Year) 6. 4-20-1965
	7. SARASOTA, FL.				
	8. NO				
	9a. PLACE OF DEATH (Check only one: see instructions on other side)				
	FACILITY NAME (If not institution, give street and number) 9b. 15 SCHMIDT TERRACE		CITY, TOWN, OR LOCATION OF DEATH 9c. HENDERSONVILLE		INSIDE CITY LIMITS? (Yes or No) 9d. NO
	MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) 10. MARRIED		SURVIVING SPOUSE (If wife, give maiden name) 11. NICOLLE PATRICIA TOBEN WATTER		DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) 12. RESTAURANT
	RESIDENCE—STATE 13a. N.C.	COUNTY 13b. HENDERSON	CITY, TOWN, OR LOCATION 13c. HENDERSONVILLE		STREET AND NUMBER 13d. 15 SCHMIDT TERRACE
	INSIDE CITY LIMITS? (Yes or No) 13a. NO	ZIP CODE 13. 28792	Was Decedent of Hispanic Origin? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (Specify)		RACE—American Indian, Black, White, Etc. (Specify) 15. WHITE
	FATHER'S NAME (First, Middle, Last) 17. PAUL AUGUST SCHMIDT		MOTHER'S NAME (First, Middle, Maiden Surname) 16. HELEN PAULA KASTNER		
INFORMANT'S NAME (Type/Print) 19a. NICOLLE SCHMIDT		MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zip Code) 19b. 19780 ATASOCIATA SHORES DR., HUMBLE, TX 77346		DATE AMENDED 19c. # 222	
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. If appropriate, enter tobacco, alcohol, or drug use. List only one cause on each line. (PRINT or TYPE)					
IMMEDIATE CAUSE (First disease or condition resulting in death) a. PENDING-AUTOPSY DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death	
Sequence of conditions any, leading to immediate cause b. SUBARACHNOID HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF):					
CAUSE(S) OF DEATH that indicated events resulting in death LAST. c. CAUSE(S) OF DEATH DUE TO (OR AS A CONSEQUENCE OF):					
20a. CAUSE(S) OF DEATH d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, such as tobacco, alcohol, or drug use; diabetes, etc.					
MANNER OF DEATH 21c. <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Not Determined		DATE OF INJURY (Month, Day, Year) 22a.	TIME OF INJURY 22b. M	INJURY AT WORK? (Yes or No) 22c.	DESCRIBE HOW INJURY OCCURRED 22d.
PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 22e.		LOCATION (Street and Number or Rural Route Number, City or Town, State) 22f.		TIME OF DEATH 22g. 0001 A M	
To the best of my knowledge, death occurred at the time, date and place stated. (Signature and Title of Certifier) 23a. <i>[Signature]</i> #4510				DATE SIGNED (Month, Day, Year) 23b. OCT 31, 2007	
NAME AND ADDRESS OF PERSON WHO COMPLETED CROSE OF DEATH (ITEM 20) (Type or Print) 24a. R.H. DOWDES WELLS, MD, HVL, NC 28739				DATE PRONOUNCED DEAD (Month, Day, Year) 24b. OCT 29, 2007	
METHOD OF DISPOSITION 25a. <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) 25b. ASHEVILLE CREMATORY		LOCATION — City or Town, State, Zip Code 25c. ASHEVILLE, N.C. 28803	
NAME AND ADDRESS OF FUNERAL HOME 26a. ASHEVILLE MORT., ASHEVILLE, N.C. 28803		NAME OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH 26b. JOE D. PENLAND SR.		LICENSE NUMBER 26c. FD 2496	
REGISTRAR'S SIGNATURE 27. <i>[Signature]</i>		DATE FILED (Month, Day, Year) 28. 11/01/2007	NAME OF EMBALMER 28d. NO EMBALMING		
				LICENSE NUMBER 28e.	

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NORTH CAROLINA DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES 063927				
DIVISION OF EPIDEMIOLOGY - VITAL RECORDS SECTION				
F200711018		SUPPLEMENTAL REPORT OF CAUSE OF DEATH		MAY 05 2008
NAME OF DECEASED Mischa August Schmidt				
DATE OF DEATH 10/29/07	COUNTY OF DEATH Henderson	SEX M	RACE White	
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)				
a. <u>Acute acetonitrile toxicity (probable huffing)</u> DUE TO (OR AS A CONSEQUENCE OF):				
Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.				
b. _____ DUE TO (OR AS A CONSEQUENCE OF):				
c. _____ DUE TO (OR AS A CONSEQUENCE OF):				
d. _____				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I			WAS AN AUTOPSY PERFORMED (YES OR NO)	Were Autopsy Findings Available Prior to Completion of Death Certificate?
20b. _____			21a. YES	21b. (Yes or No) YES
MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide 21c. <input type="checkbox"/> Homicide <input type="checkbox"/> Pending <input type="checkbox"/> Not Determined	DATE OF INJURY (Month, Day, Year) 22a.	TIME OF INJURY 22b.	INJURY AT WORK? (YES OR NO) 22c.	DESCRIBE HOW INJURY OCCURRED 21d.
PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) 22e.	LOCATION (Street and Number or Rural Route Number, City or Town, State) 22f.		TIME OF DEATH 22g.	
To the best of my knowledge, death occurred at the time, date and place stated. (Signature and Title of Certifier)			DATE SIGNED (Month, Day, Year)	
23a.  #44510			23b. APR 21, 2008	
NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type or Print)			DATE PRONOUNCED DEAD (Month, Day, Year)	
24a. Robert H. Dowdeswell, MD Flat Rock, NC 28731			24b. OCT 29, 2007	

Note: All entries in the medical and cause-of-death section supersede the corresponding entries on the original certificate.

[Handwritten signature/initials]