STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

CAL FILE NO. 07 013882

1. DECEDENT'S NAME (First, Middle, Last, Suffix): SCOTT BIGELOW					2. SEX: Male
3. DATE OF BIRTH (Month, Day, Year): September 1, 1961	4a. AGE-Last Birthday (Years): 45	4b. UNDER 1 YEAR: Months / Days	4c. UNDER 1 DAY: Hours / Minutes	5. DATE OF DEATH (Month, Day, Year): Found January 19, 2007	
6. SOCIAL SECURITY NUMBER: 151-62-3909	7. BIRTHPLACE (City and State or Foreign Country): Jersey City, New Jersey			8. COUNTY OF DEATH: Pasco	

9. PLACE OF DEATH (Check only one)
HOSPITAL: ___ Inpatient ___ Emergency Room/Outpatient ___ Dead on Arrival
NON-HOSPITAL: ___ Hospice facility ___ Nursing Home/Long Term Care Facility X Decedent's Home ___ Other (Specify)

10. FACILITY NAME (If not institution, give street address): 12314 Morgan Road	11a. CITY, TOWN, OR LOCATION OF DEATH: Hudson	11b. INSIDE CITY LIMITS? ___ Yes X No

12. MARITAL STATUS (Specify): ___ Married ___ Married, but Separated ___ Widowed X Divorced ___ Never Married

13. SURVIVING SPOUSE'S NAME (If wife, give maiden name):

14a. RESIDENCE - STATE: Florida	14b. COUNTY: Pasco	14c. CITY, TOWN, OR LOCATION: Hudson	
14d. STREET ADDRESS: 12314 Morgan Road	14e. APT. NO.	14f. ZIP CODE: 34669	14g. INSIDE CITY LIMITS? ___ Yes X No

15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired": Professional Wrestler	15b. KIND OF BUSINESS/INDUSTRY: Entertainment

16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.)
X White ___ Black or African American ___ American Indian or Alaskan Native (Specify tribe)
___ Asian Indian ___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Vietnamese ___ Other Asian (Specify)
___ Native Hawaiian ___ Guamanian or Chamorro ___ Samoan ___ Other Pacific Isl. (Specify) ___ Other (Specify)

17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) ___ Yes (If Yes, specify) X No ___ Mexican ___ Puerto Rican ___ Cuban ___ Central/South American ___ Other Hispanic (Specify) ___ Haitian

18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.) ___ 8th or less ___ High school but no diploma X High school diploma or GED ___ College but no degree College degree (Specify): ___ Associate ___ Bachelor's ___ Master's ___ Doctorate	19. WAS DECEDENT EVER IN U.S. ARMED FORCES? ___ Yes X No

20. FATHER'S NAME (First, Middle, Last, Suffix): William Bigelow	21. MOTHER'S NAME (First, Middle, Maiden Surname): Diana Manino	
22a. INFORMANT'S NAME: Todd Bigelow	22b. RELATIONSHIP TO DECEDENT: Brother	23a. INFORMANT'S MAILING - STATE: Florida
23b. CITY OR TOWN: Spring Hill	23c. STREET ADDRESS: 6441 Covewood Drive	23d. ZIP CODE: 34609

24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Monmouth Memorial Park	25a. LOCATION - STATE: New Jersey	25b. LOCATION - CITY OR TOWN: Tinton Falls

26a. METHOD OF DISPOSITION ___ Burial ___ Entombment ___ Cremation ___ Donation X Removal from State ___ Other (Specify)

26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? X Yes ___ No	27a. LICENSE NUMBER (of Licensee): 3163	27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ►
28. NAME OF FUNERAL FACILITY: Loyless Funeral Home		29a. FACILITY'S MAILING - STATE: Florida
29b. CITY OR TOWN: Land O' Lakes	29c. STREET ADDRESS: 5310 Land O' Lakes Blvd	29d. ZIP CODE: 34639

30. CERTIFIER: (Check one) ___ 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.
✓ 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 of Certifier) ► PHYSICIAN'S SIGNATURE	31b. DATE SIGNED (mm/dd/yyyy): 05/01/2007	32. TIME OF DEATH (24 hr.): Found 1031	33. MEDICAL EXAMINER'S CASE NUMBER: 0 7 . 0 6 . 0 0 7 5
34a. LICENSE NUMBER (of Certifier): ME 80313	34b. CERTIFIER'S NAME: Susan Ignacio, M.D., M.E.	35. NAME OF ATTENDING PHYSICIAN (If other than Certifier):	

36a. CERTIFIER'S - STATE: Florida	36b. CITY OR TOWN: Largo	36c. STREET ADDRESS: 10900 Ulmerton Rd.	36d. ZIP CODE: 33778
37. SUBREGISTRAR - Signature and Date ► 5/1/07	38a. LOCAL REGISTRAR - Signature ►	38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.): MAY 3 2007	

VOID IF ALTERED OR ERASED

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