STATE OF FLORIDA

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# OFFICE of VITAL STATISTICS

## CERTIFICATE OF DEATH
## FLORIDA

LOCAL FILE NO. 39-03-001331

03-022756

**DECEDENT**

| 1. DECEDENT'S NAME | FIRST | MIDDLE | LAST | 2. SEX |
|---|---|---|---|---|
| | CURTIS | MICHAEL | HENNIG | Male |

| 3. DATE OF DEATH (Month, Day, Year) | 4. SOCIAL SECURITY NUMBER | 5a. AGE Last Birthday (years) | 5b. UNDER 1 YEAR: Months | Days | 5c. UNDER 1 Day: Hours | Minutes |
|---|---|---|---|---|---|---|
| February 10, 2003 | 473-58-4167 | 44 | | | | |

| 6. DATE OF BIRTH (Month, Day, Year) | 7. BIRTHPLACE (City and State or Foreign Country) | 8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) |
|---|---|---|
| March 28, 1958 | Robbinsdale, Minnesota | No |

9a. PLACE OF DEATH (Check only one; see instructions on other side): HOSPITAL: ___ Inpatient ___ ER/Outpatient ___ DOA OTHER: ___ Nursing Home ___ Residence X Other (Specify) Motel/Hotel Room

9b. INSIDE CITY LIMITS? (Yes or No): No

| 9c. FACILITY NAME (If not institution, give street and number) | 9d. CITY, TOWN, OR LOCATION OF DEATH | 9e. COUNTY OF DEATH |
|---|---|---|
| 330 Grand Regency Bl Room #254 | Brandon | Hillsborough |

| 10a. DECEDENT'S USUAL OCCUPATION | 10b. KIND OF BUSINESS/INDUSTRY | 11. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify) | 12. SURVIVING SPOUSE (If wife, give maiden name) |
|---|---|---|---|
| Professional Wrestler | Entertainment | Married | Leonice Leonard |

**PARENTS**

| 13a. RESIDENCE – STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Minnesota | Hennepin | Champlin | 607 W. River Parkway |

| 13e. INSIDE CITY LIMITS? (Yes or No) | 13f. ZIP CODE | 14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes – If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) | 15. RACE – American Indian, Black, White, etc. Specify: | 16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0 - 12) | College (1-4 or 5 +) |
|---|---|---|---|---|---|
| Yes | 55316 | X No ___ Yes Specify: | White | | 1 |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Larry Hennig | Irene Leckner |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Leonice Hennig | 607 W. River Parkway, Champlin, Minnesota 55316 |

**DISPOSITION**

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 20c. LOCATION – City or Town, State |
|---|---|---|
| ___ Burial ___ Cremation X Removal from State ___ Donation ___ Other (Specify) | Gethsemane Cemetery | New Hope, Minnesota |

**CERTIFIER**

| 21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH | 21b. LICENSE NUMBER (of Licensee) | 21c. NAME AND ADDRESS OF FACILITY |
|---|---|---|
| ▸ William T. Bartlett | 2631 | Loyless Funeral Home<br>5310 Land O' Lakes Blvd<br>Land O' Lakes, Florida 34639 |

To be Completed by CERTIFYING PHYSICIAN Only:

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) ▸

22b. DATE SIGNED (Mo., Day, Yr.)

22c. HOUR OF DEATH M

22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To be Completed by MEDICAL EXAMINER:

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) ▸ Jacqueline A. Lee

23b. DATE SIGNED (Mo., Day, Yr.) March 19, 2003

23c. HOUR OF DEATH 1:00 P M

23d. MEDICAL EXAMINER'S CASE # 03-13-00917

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print): Jacqueline A. Lee, M.D. — Medical Examiner Department, 401 S. Morgan St., Tampa, FL 33602

| 25a. SUBREGISTRAR – SIGNATURE AND DATE | 25b. LOCAL REGISTRAR – SIGNATURE | 25c. DATE REGISTERED |
|---|---|---|
| ▸ Virginia Hutchinson 3/24/03 | ▸ | MAR 25 2003 |

C. Meade Hogg, State Registrar

Date Issued: FEB 03 2011

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

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*P711LLA3U*

DH FORM 1946 (04-10)

CERTIFICATION OF VITAL RECORD

FLORIDA DEPARTMENT OF HEALTH

VOID IF ALTERED OR ERASED

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