0000201401001

Form R-363-07012014

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

DEATH CERTIFICATE ATTESTATION COPY

DECEDENT – NAME FIRST: AARON | MIDDLE: JOSEF | LAST: HERNANDEZ | GENERATIONAL ID:

DATE OF DEATH	SEX	PLACE OF DEATH – CITY/TOWN	DATE OF BIRTH
APRIL 19, 2017	MALE	LEOMINSTER	[redacted]

MEDICAL RECORD NUMBER	PLACE OF DEATH
---	HOSPITAL - DOA

HOSPITAL OR OTHER INSTITUTION – NAME: HEALTHALLIANCE HOSPITAL

PART I – CAUSE OF DEATH – SEQUENTIALLY LIST IMMEDIATE CAUSE THEN ANTECEDENT CAUSES THEN UNDERLYING CAUSE	APPX INTERVAL
a) Immediate Cause: ASPHYXIA BY HANGING	— MIN.
b) Due to: ---	---
c) Due to: ---	---
d) Due to: ---	---

PART II – OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH	ME NOTIFIED?	AUTOPSY PERFORMED?
---	YES	YES - ME
	AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETING CAUSE OF DEATH? NO	

MANNER OF DEATH	ME CASE NUMBER	DATE OF INJURY	TIME OF INJURY	INJURY AT WORK?
SUICIDE	2017-5201	APRIL 19, 2017	UNKNOWN	NO

PLACE OF INJURY	TRANSPORTATION INJURY
PRISON CELL	—

LOCATION/ADDRESS OF INJURY: 1 HARVARD ROAD, SHIRLEY, MASSACHUSETTS 01464

DESCRIBE HOW INJURY OCCURRED	DID TOBACCO USE CONTRIBUTE TO DEATH?	APPX TIME OF DEATH
HANGED HIMSELF	NO	04:07 AM

IF FEMALE, PREGNANCY STATUS AT TIME OF DEATH	ME DATE PRONOUNCED	ME TIME PRONOUNCED
—	APRIL 19, 2017	04:07 AM

MEDICAL CERTIFIER INFORMATION – NAME/TITLE: HENRY M. NIELDS, MD | HOUR OF DEATH: —

MEDICAL CERTIFIER INFORMATION – ADDRESS: 720 ALBANY STREET, BOSTON, MASSACHUSETTS 02118 | LICENSE #: 78065

MEDICAL CERTIFIER DESIGNATION: MEDICAL EXAMINER

MEDICAL CERTIFIER FAX NUMBER TO RECEIVE ATTESTATION FORM	MEDICAL CERTIFIER PHONE NUMBER
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PROVIDER IN CHARGE OF PATIENT'S CARE – NAME/TITLE: ---

RN/PA/NP PRONOUNCEMENT?	IF YES, DATE	IF YES, TIME	PRONOUNCER INFORMATION – NAME/TITLE
NO	---	---	---

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) stated.

/s HENRY M. NIELDS, MD

DATE SIGNED (MM/DD/YYYY): APRIL 20, 2017

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE CHIEF MEDICAL EXAMINER

CME CASE # 17-521

PREPARE IN TRIPLICATE

STANDARD PROPERTY LIST

(PLEASE PRINT)

CLOTHING LIST: (DESCRIBE BY COLOR AND INITIAL ITEM WHERE APPLICABLE)

PANTS OR SLACKS

DRESS OR SKIRT

SHIRT OR BLOUSE

UNDERWEAR

SOCKS OR STOCKINGS

SHOES

NECKTIES, SCARVES, ETC.

COATS, JACKETS, ETC.

BELTS

SLEEPWEAR, GOWNS, ETC.

OTHER CLOTHING

RECEIVED BY:

WITNESS BY:

*IF BY POLICE GIVE ID NO. IF BY NURSE, ORDERLY, ETC. PLEASE SO STATE.

WEAPONS: FIREARMS, KNIVES, ETC.

(STATE DISPOSITION OF)

SIGNATURE OF FUNERAL DIRECTOR OR OTHER AUTHORIZED PERSON RECEIVING PROPERTY FOR WHICH HE/SHE HAS INITIALED:

REG. NO.

WITNESS:

Admission Blood

PLEASE LIST ADDITIONAL PROPERTY IN THIS SPACE AND INITIAL:

DATE: 4/19/17.

NAME: Aaron Hernandez

ADDRESS OR HOSPITAL: [illegible]

TIME: 10:30 (AM) PM

VALUABLES LIST & INITIAL EACH ITEM WHERE APPLICABLE:

WALLET

PURSE

CURRENCY

CHANGES

WATCHES

RINGS (DESCRIBE BY COLOR OF METAL AND STONES)

KEYS AND KEY RINGS, CHAINS, ETC.

BANK BOOKS, CHECKS, ETC.

DATE:

TIME: AM PM

PLEASE INDICATE: BODY BAG USED (YES NO)

PLEASE INDICATE: BODY BAG EXCHANGED (YES NO)