

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

3107922 COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

COMMONWEALTH OF VIRGINIA - CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS - RICHMOND

MEDICAL EXAMINER'S CERTIFICATE				DATE RECORD FILED MARCH 30, 2021		STATE FILE NUMBER 21-021116	
1. FULL NAME OF DECEDENT (first) DONOVAN		(middle) WAYNE		(last) LYNCH		(suffix)	
2. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> NOT DETERMINED		3. DATE OF DEATH MARCH 27, 2021		4. DATE OF BIRTH APRIL 17, 1995		5. AGE Years 25	
6. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		7. BIRTHPLACE (U.S. STATE OR FOREIGN COUNTRY) VIRGINIA		8. SOCIAL SECURITY NUMBER 228 - 73 - 4197		9. IF NO SSN, CHECK APPROPRIATE BOX <input type="checkbox"/> NONE <input type="checkbox"/> NOT OBTAINABLE <input type="checkbox"/> UNKNOWN	
9. STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.) 5428 SAFE HARBOUR WAY				10. CITY OR TOWN OF RESIDENCE VIRGINIA BEACH			
11. COUNTY OF DECEDENT'S RESIDENCE (if independent city, leave blank)				12. U.S. STATE (OR FOREIGN COUNTRY) OF DECEDENT'S RESIDENCE VIRGINIA		13a. ZIP CODE 23462	
13. RACE OF DECEDENT (CHECK ONE OR MORE) <input type="checkbox"/> WHITE <input checked="" type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HAWAIIAN <input type="checkbox"/> KOREAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE (SPECIFY) <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> SAMBIAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER PACIFIC ISLANDER (SPECIFY) <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> JAPANESE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER ASIAN (SPECIFY) <input type="checkbox"/> OTHER (SPECIFY)							
14. DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> NON-HISPANIC <input type="checkbox"/> CENTRAL OR SOUTH AMERICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> MEXICAN <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> OTHER (SPECIFY) <input type="checkbox"/> UNKNOWN							
15. EDUCATION (HIGHEST GRADE COMPLETED) <input type="checkbox"/> ASSOCIATE DEGREE <input checked="" type="checkbox"/> BACHELOR'S DEGREE <input type="checkbox"/> MASTER'S DEGREE <input type="checkbox"/> ELEMENTARY/SECONDARY (0-12) <input type="checkbox"/> HIGH SCHOOL DIPLOMA <input type="checkbox"/> GED <input type="checkbox"/> YEARS OF COLLEGE: _____ <input type="checkbox"/> DOCTORATE/PROFESSIONAL DEGREE <input type="checkbox"/> UNKNOWN							
16. CITIZEN OF WHAT COUNTRY UNITED STATES OF AMERICA				17. USUAL OR LAST OCCUPATION ENTREPRENEUR		18. KIND OF BUSINESS OR INDUSTRY SMALL BUSINESS	
19. MARITAL STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN							
20. IF MARRIED, SEPARATED OR WIDOWED, NAME OF SPOUSE (if divorced leave blank)				21. FULL NAME OF DECEDENT'S FATHER OR PARENT (if first, middle, last, and/or maiden name, if any) WAYNE LYNCH			
22. FULL NAME OF DECEDENT'S MOTHER OR PARENT (if first, middle, last, and/or maiden name, if any) MARVA SILLS				23a. GENDER MALE			
23. INFORMANT'S RELATIONSHIP OR SOURCE OF INFORMATION FATHER/PARENT II				24. FULL NAME OF INFORMANT OR NAME OF SOURCE WAYNE LYNCH			
25. NAME OF HOSPITAL OR INSTITUTION OF DEATH (if none, so state) NONE						25a. SELECT ONE IF DEATH OCCURRED IN HOSPITAL <input type="checkbox"/> DOA <input type="checkbox"/> OUT PAT. EXH. RM <input type="checkbox"/> INPATIENT	
26. SPECIFY IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> NURSING HOME <input type="checkbox"/> LONG TERM CARE FACILITY <input type="checkbox"/> DECEDENT'S HOME <input type="checkbox"/> CORRECTIONAL FACILITY <input checked="" type="checkbox"/> OTHER (SPECIFY) ROAD							
27. CITY OR TOWN OF DEATH VIRGINIA BEACH		28. STREET ADDRESS OR RT. NO. OF PLACE OF DEATH 20TH STREET				29a. ZIP CODE	
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> BURIAL AT SEA <input type="checkbox"/> REMOVAL FROM STATE (IF KNOWN, PLEASE ALSO CHECK FINAL METHOD OF DISPOSITION WHEN REMOVING FROM STATE, FROM OPTIONS SHOWN)		<input type="checkbox"/> ENTOMBMENT / MAUSOLEUM <input type="checkbox"/> DONATION		<input type="checkbox"/> CREMATION / INCINERATION <input type="checkbox"/> OTHER (SPECIFY)		<input type="checkbox"/> CREMATION WITH BURIAL <input type="checkbox"/> CREMATION WITH ENTOMBMENT / MAUSOLEUM	
30. PLACE OF DISPOSITION - NAME OF CEMETERY OR CREMATORY PRINCESS ANNE MEMORIAL PARK							
31. PLACE OF DISPOSITION - STREET ADDRESS OF CEMETERY OR CREMATORY 1110 NORTH GREAT NECK ROAD		31a. CITY / COUNTY VIRGINIA BEACH		31b. STATE VIRGINIA		31c. ZIP CODE 23454	
32. SIGNATURE OF FUNERAL DIRECTOR/LICENSEE, VSAP OR NEXT OF KIN (ACTUAL SIGNATURE) /S/ KEVIN ANDRE SANDERLIN		32a. LICENSE NO. 0502900526		32b. NAME OF FUNERAL HOME OR FACILITY BEACH FUNERAL & CREMATION SERVICES, INC.			
33. NAME OF FUNERAL DIRECTOR / LICENSEE, VSAP OR NEXT OF KIN KEVIN ANDRE SANDERLIN		33a. STREET ADDRESS OF FUNERAL HOME / FACILITY, VSAP OR NEXT OF KIN (include street address, city, state and zip code) 4456 BONNEY RD VIRGINIA BCH VIRGINIA 23462					
34. TIME OF DEATH: To the best of my knowledge, death occurred at 12:07 <input checked="" type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> ACTUAL <input type="checkbox"/> APPROXIMATE <input type="checkbox"/> PRESUMED <input checked="" type="checkbox"/> FOUND							
35. PART I. Enter the diseases, injuries, or complications that caused the death. Do not omit the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE OF DEATH (A) GUNSHOT WOUNDS TO THE TORSO AND THIGH.							
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) _____ DUE TO (OR AS A CONSEQUENCE OF) _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
36. WAS THE MEDICAL EXAMINER CONTACTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		36a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		36b. WERE FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> POSSIBLY <input type="checkbox"/> UNKNOWN	
38. IF FEMALE: <input type="checkbox"/> PREGNANT AT TIME OF DEATH <input type="checkbox"/> UNKNOWN IF PREGNANT WITHIN THE PAST YEAR <input type="checkbox"/> NOT PREGNANT, BUT PREGNANT WITHIN 42 DAYS OF DEATH <input type="checkbox"/> NOT PREGNANT WITHIN PAST YEAR <input type="checkbox"/> NOT PREGNANT, BUT PREGNANT WITHIN 43 DAYS TO 1 YEAR BEFORE DEATH <input type="checkbox"/> NOT APPLICABLE (if decedent's age is 0-5 or 75 years)							
39. IF EXTERNAL TO WHAT EXTENT IT CONTRIBUTED TO CAUSE OF DEATH? <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING				40. MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> UNDETERMINED <input type="checkbox"/> PENDING			
41. DATE OF INJURY MARCH 26, 2021		42. TIME OF INJURY 11:52 <input type="checkbox"/> A.M. <input checked="" type="checkbox"/> P.M.		43. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		44. PLACE OF INJURY (home, farm, factory, street, office, h/d/g, etc.) OUTDOORS	
45. LOCATION OF INJURY - STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.) 20TH STREET		45a. CITY / COUNTY VIRGINIA BEACH		45b. STATE VIRGINIA		45c. ZIP CODE	
46. IF TRANSPORTATION INJURY, SPECIFY <input type="checkbox"/> DRIVER OPERATOR <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> OTHER (SPECIFY)							
47. DESCRIBE HOW INJURY RELATING TO DEATH OCCURRED SHOT WITH HANDGUN.							
48. SIGNATURE OF MEDICAL EXAMINER /S/ NICOLE MARIE MASIAN				48a. NAME OF MEDICAL EXAMINER NICOLE MARIE MASIAN		48b. DATE SIGNED: MARCH 29, 2021	
49. OFFICE STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.) 830 SOUTHAMPTON AVENUE SUITE 100				49a. CITY NORFOLK		49b. STATE VIRGINIA	
				49c. ZIP CODE 23510			

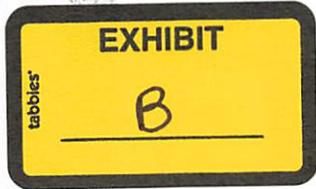


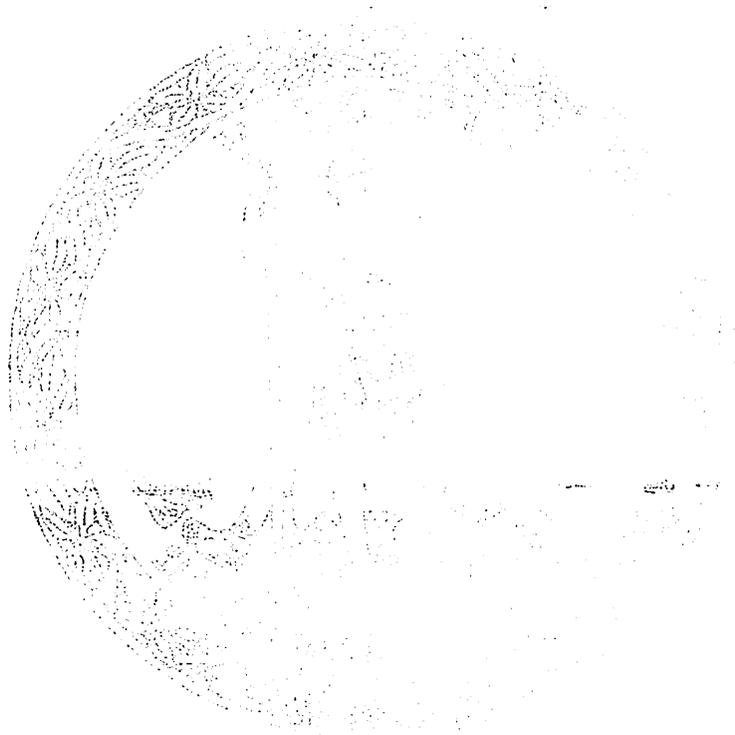
This is to certify that this is a true and correct reproduction or abstract of the official record filed with the Virginia Department of Health, Richmond, Virginia

DATE ISSUED **MARCH 31, 2021**

Janet M. Rainey
Janet M. Rainey, State Registrar

Do not accept unless on security paper with the seal of Virginia Department of Health, Vital Statistics in the lower left hand corner. Section 32.1-272, Code of Virginia, as amended. VS 15C





Dear Sir or Madam,

This document is a record of the information provided at the time of the event. This certificate is a legal document and all information should be reviewed for accuracy. If you have any questions or concerns please return the certificate (if necessary) with a letter of explanation to:

State Health Department
Division of Vital Records
P.O. Box 1000
Richmond, VA 23218