

Beaufort County Coroner's Office

J. Edward Allen, Coroner
 Post Office Drawer 1228
 Beaufort, South Carolina 29901
 843-255-5150 eda@bcgov.net or jhorton@bcgov.net

Coroner Summary Report

Case # 17-0584	Coroner's Office Investigators	1 David W. Ott	2
		3	4
Name of Deceased Geoffrey Hammond		Age 69 Years	DOB 8/15/1947
		Sex Male	Race White
Address of Deceased 12 Hanover Way		City Bluffton	State South Carolina
			Zip 29910
Date of Death 6/14/2017	Time of Death 10:33 AM		Location of Death 12 Hanover Way Bluffton, SC
Agency Reported To Dispatch / EMS	Person Reporting Death		Person Certifying Death J. Edward Allen, Coroner
NOK Name Jayne Hammond, wife	NOK Address 12 Hanover Way, Bluffton, 29910		NOK Phone (843) 706 - 0668
Identified By Jayne Hammond		How Identified Family	
Deceased Employer		Funeral Home Carolina Mem. FH for Menorah Gardens Funeral Chapl	
Autopsy Requested? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Autopsy Performed? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Where Autopsy Performed MUSC	Doctor Performing Autopsy Dr Nicholas Batalis
Cause of Death Atherosclerotic cardiovascular disease		Manner of Death Natural	Mechanism of Death

Case Summary

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Coroner Summary Report

On the morning of 06-14-17 at about 0730, the decedent and his wife got up from bed. According to his wife, for unknown reason the decedent burped very loudly when he first got up. She advised he never did that in the past. At 0945, the decedent told his wife he was going upstairs to his study to crunch numbers. At about 1005, his wife heard a loud sound like something falling. Upon going upstairs, she found the decedent unresponsive on the study floor in a prone position. She called 911 at 1009 then attempted to roll him over to start CPR however was not able to roll him. EMS arrived at 1022 and started standard protocol with CPR in progress. They continued until HHRMC ordered them to stop. The decedent was pronounced dead at 1033. The decedent's wife advised he never stated he had chest pains, felt tired etc leading up to this event. There was no evidence of him working on his computer, paper work nor anything else. At his last doctor's visit on 06-05-17, he reported severe fatigue that has been gradually worsening to his doctor. Lab work was ordered on the decedent. According to his doctor today, the lab work came back with it all being found in good shape. He was taking Crestor 20 mg.



Supplemental Report of Medical Certification of Death Public Health Statistics and Information Services

Death Certificate No.:

(State Office Use Only)

Name of Deceased: Geoffrey Hammond Age: 69
 Date of Death: 6-14-2017 County of Death: Beaufort Sex: M Race: W

Reason for supplemental information:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Autopsy Findings.
<input type="checkbox"/> Additional information for Classifying Cause of Death.
<input type="checkbox"/> Other, specify: _____ | <input checked="" type="checkbox"/> Cause of Death Pending on Original Certificate.
<input type="checkbox"/> Requested by physician/coroner/medical examiner.
<input checked="" type="checkbox"/> Manner of death and/or accident information. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

CAUSE OF DEATH	ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH		24. DATE PRONOUNCED DEAD (MM/DD/YYYY)		25. TIME PRONOUNCED DEAD	
	26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)			27. LICENSE NUMBER		28. DATE SIGNED (MM/DD/YYYY)
	29. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY)		30. ACTUAL OR PRESUMED TIME OF DEATH		31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	CAUSE OF DEATH (See instructions and examples) 32. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <u>Atherosclerotic cardiovascular disease</u> Due to (or as a consequence of): _____ b. _____ Due to (or as a consequence of): _____ c. _____ Due to (or as a consequence of): _____ d. _____ Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST					Approximate interval: Onset to death _____ _____ _____
To Be Completed By: MEDICAL CERTIFIER	PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.				33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to one year before death <input type="checkbox"/> Unknown if pregnant within the past year		37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined	
	38. DATE OF INJURY (MM/DD/YYYY)		39. TIME OF INJURY	40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area)		41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
	42. LOCATION OF INJURY: State: _____ City or Town: _____ County: _____ Street & Number: _____ Apartment Number: _____ Zip Code: _____			43. DESCRIBE HOW INJURY OCCURRED:		
	44. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify) _____					

*Additional information requested:

After the completion of the autopsy, toxicology and investigation, complete the Cause of Death and items 33 - 37 above. If this is a traumatic death, then you MUST complete items 38 - 44 above.

Janet C. Horton, 7-11-2017
 Signature and Title of Certifying Officer Date Signed

Janet C. Horton, Administrative Deputy Coroner
 Beaufort County
 Post Office 1228
 Beaufort, South Carolina 29901

(State Office Use Only)

Death certificate updated pursuant to SC Reg. 61-19,
 Section 18(f) _____

 (Nosologist)

NAME OF DECEDENT
For use by physician or institution

1. DECEDENT'S LEGAL NAME (Include AKA's, if any) (First, Middle, Last) Paul Geoffrey Hammond				2. SEX Male		3. SOCIAL SECURITY 146-40-0388	
4a. AGE-Last Birthday (Years) 69		4b. UNDER 1 YEAR Months _____ Days _____		4c. UNDER 1 DAY Hours _____ Minutes _____		5. DATE OF BIRTH (MM/DD/YYYY) 08/15/1947	
6. BIRTHPLACE (City and State or Foreign Country) Montclair, NJ				7a. RESIDENCE-STATE South Carolina		7b. COUNTY Beaufort	
7c. CITY OR TOWN Bluffton				7d. STREET AND NUMBER 12 Hanover Way		7e. APT. NO. _____	
7f. ZIP CODE 29910				7g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
8. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		9. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		10. SURVIVING SPOUSE'S NAME (# Wife, give name prior to first marriage) Jayne Hermann			
11. FATHER'S NAME (First, Middle, Last) Donald Hammond				12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Rosemary Strenz			
13a. INFORMANT'S NAME Jayne Hammond		13b. RELATIONSHIP TO DECEDENT Wife		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 373 Mizer Lake Estate Boca Raton, Florida 33432			
14. PLACE OF DEATH (Check only one: see instructions)							
IF DEATH OCCURRED IN HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival				IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input checked="" type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify) _____			
15. FACILITY NAME (If not institution, give street and number) 12 Hanover Way				16. CITY OR TOWN, STATE AND ZIP CODE Bluffton, South Carolina 29910		17. COUNTY OF DEATH Beaufort	
18. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Removal from state <input type="checkbox"/> Other (Specify) _____				19. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place) Menorah Gardens Cemetery			
20. LOCATION-CITY, TOWN AND STATE Southwest Ranches, Florida				21. NAME AND ADDRESS OF FUNERAL FACILITY Carolina Memorial FH For Menorah Gardens			
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT				23. LICENSE NUMBER (Of Licensee) 7113 Rivers Ave North Charleston, SC 29406		23c. LICENSE NUMBER (Of Facility) 1002	
23a. EMBALMER (Signature) Roger Rose				23b. EMBALMER LICENSE NUMBER 3917		23c. LICENSE NUMBER (Of Facility) 1002	
24. DATE PRONOUNCED DEAD (MM/DD/YYYY)				25. TIME PRONOUNCED DEAD			
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable) Deborah A Youmans				27. LICENSE NUMBER Deputy Coroner		28. DATE SIGNED (mm/dd/yyyy)	
29. ACTUAL OR PRESUMED DATE OF DEATH (Spell Month) June 14, 2017				30. ACTUAL OR PRESUMED TIME OF DEATH 10:33 AM		31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
32. PART 1. Enter the chain of events - disease, injuries, or complications - that directly caused the death. DO NOT enter terminal events additional lines if necessary. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Pending tox and autopsy results Due to (or as a consequence of): _____ Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated, the 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): _____							Approximate interval Onset to death
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.							33. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to one year before death <input type="checkbox"/> Unknown if pregnant within the past year		37. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined			
38. DATE OF INJURY (Spell Month)		39. TIME OF INJURY		40. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)		41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
42. LOCATION OF INJURY: State _____ City or Town: _____ County: _____ Street & Number: _____ Apartment Number: _____ Zip Code: _____							
43. DESCRIBE HOW INJURY OCCURRED: _____							
44. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify) _____							
45. CERTIFIER (Check only one) <input type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing and 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 <input checked="" type="checkbox"/> Coroner/Medical Examiner-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 stated Signature of certifier: J. Edward Allen (Electronically Certified)							
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32) J. Edward Allen, Post Office Drawer 1228 Beaufort South Carolina 29901				46a. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER			
47. TITLE OF CERTIFIER Coroner		48. LICENSE NUMBER		49. DATE CERTIFIED (MM/DD/YYYY) 6/16/2017		50. FOR REGISTRAR ONLY - DATE FILED (MM/DD/YYYY)	
51. DECEDENT'S EDUCATION- Check the box that best describes the highest degree or level of school completed at the time of death. <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th-12th grade; no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input checked="" type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		52. DECEDENT OF HISPANIC ORIGIN?-Check the box that best describes whether the decedent is Spanish/Hispanic/Latino/ Latina. Check the "No" box if decedent is not Spanish/Hispanic/Latino/ Latina. <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino/Latina (Specify) _____		53. DECEDENT'S RACE-(Check one or more races to indicate what the decedent considered himself or herself to be) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____			
54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE THE TERM "RETIRED") CEO							
55. KIND OF BUSINESS/INDUSTRY							

Items 1-23c To Be Completed/Verified By: FUNERAL DIRECTOR

Items 24-49 To Be Completed By: MEDICAL CERTIFIER

Items 51-55 To Be Completed By: Funeral Director

Amendment Code _____
Amendment Number: _____
Date: _____
User ID: _____
BRTP NO. **290568**
DHEC 670 Rev. 2004