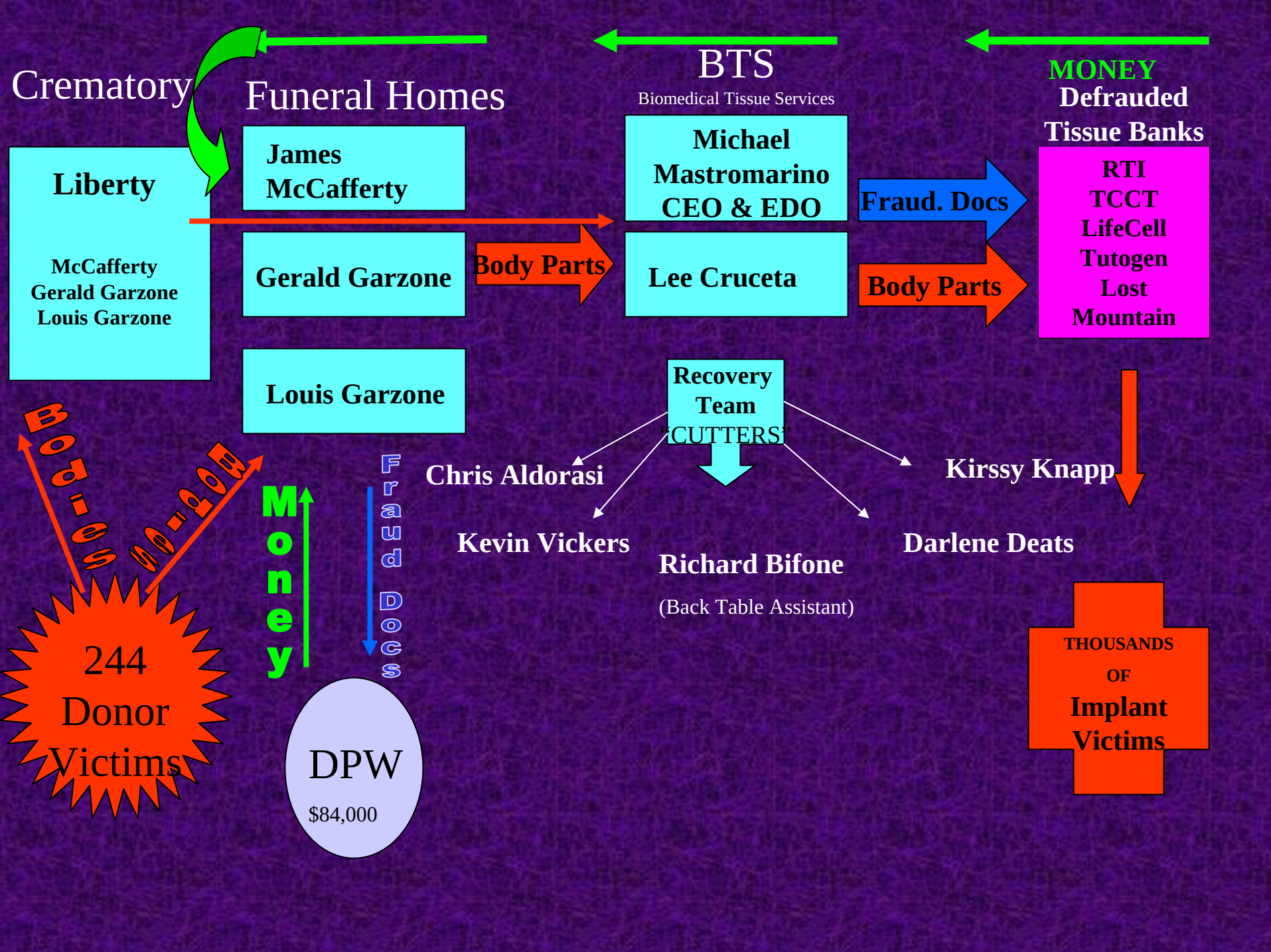
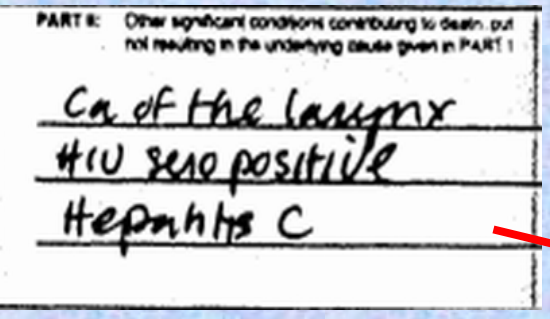
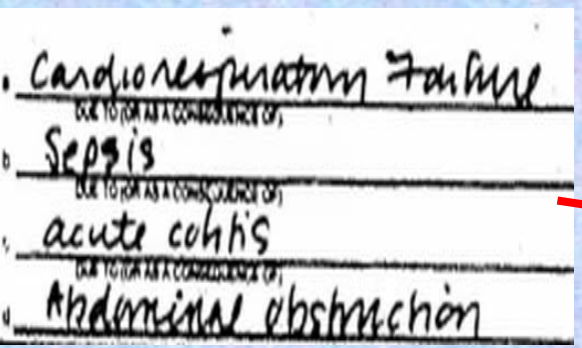

Crematory
Funeral Homes
BTS
Biomedical Tissue Services
MONEY
Defrauded Tissue Banks
Liberty
McCafferty
Gerald Garzone
Louis Garzone
James McCafferty
Gerald Garzone
Louis Garzone
Body Parts
Michael Mastromarino CEO & EDO
Lee Cruceta
Fraud. Docs
Body Parts
RTI
TCCT
LifeCell
Tutogen
Lost Mountain
Recovery Team
"CUTTERS"
Chris Aldorasi
Kevin Vickers
Richard Bifone
(Back Table Assistant)
Kirssy Knapp
Darlene Deats
Bodies
Money
Fraud Docs
244 Donor Victims
DPW
$84,000
THOUSANDS OF Implant Victims

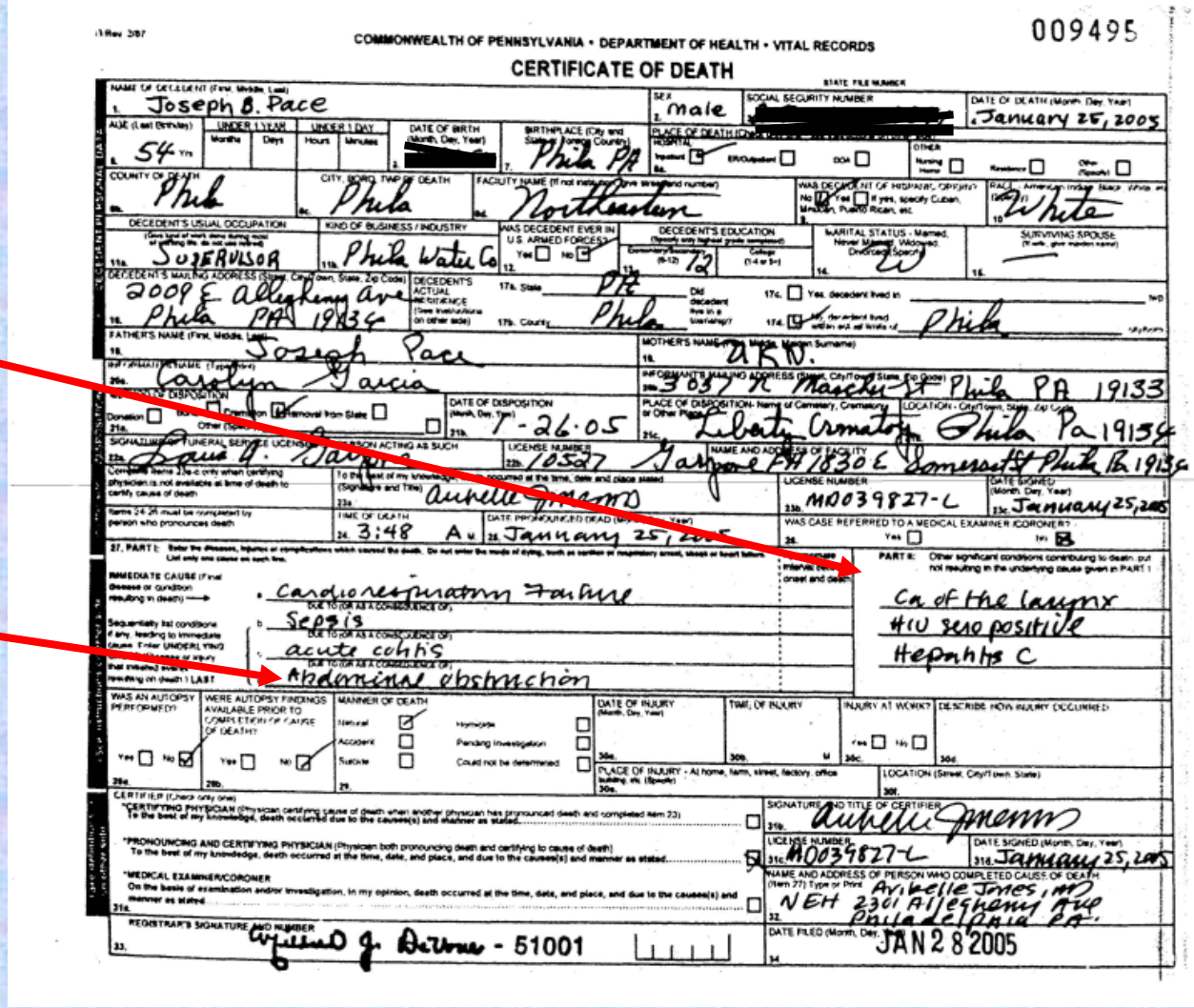
The Official Death Certificate

Home


PART II: Other significant conditions contributing to death, but not resulting in the underlying cause given in PART I

Ca of the larynx
HIV sero positive
Hepatitis C


a. Cardiorespiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c. acute colitis
DUE TO (OR AS A CONSEQUENCE OF):
d. Abdominal obstruction


009495

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

CERTIFICATE OF DEATH

1. Joseph B. Pace
2. Male
SOCIAL SECURITY NUMBER [redacted]
DATE OF DEATH: January 25, 2005
3. AGE: 54 Yrs
6. DATE OF BIRTH [redacted]
7. BIRTHPLACE: Phila PA
8a. COUNTY OF DEATH: Phila
8b. CITY, BORO, TWP OF DEATH: Phila
8c. FACILITY NAME: Northeastern
9. DECEDENT'S USUAL OCCUPATION: SUPERVISOR
10. KIND OF BUSINESS / INDUSTRY: Phila Water Co
11. WAS DECEDENT EVER IN U.S. ARMED FORCES? No
12. DECEDENT'S EDUCATION: 12
13. MARITAL STATUS: Widowed
14. SURVIVING SPOUSE: N/A
15. RACE: White
16. DECEDENT'S MAILING ADDRESS: 2009 E Allegheny Ave Phila PA 19134
17a. DECEDENT'S ACTUAL PLACE OF DEATH: Phila PA
17b. County: Phila
17c. Did decedent live in city limits? No
17d. Did decedent live on a farm? No
18. FATHER'S NAME: Joseph Pace
19. MOTHER'S NAME: UKN.
20a. INFORMANT'S NAME: Carolyn Garcia
20b. INFORMANT'S MAILING ADDRESS: 3037 N. Marshall St Phila PA 19133
21a. METHOD OF DISPOSITION: Cremation
21b. DATE OF DISPOSITION: 1-26-05
21c. PLACE OF DISPOSITION: Liberty Cremator
LOCATION: Phila Pa 19134
22a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Louis G. Garone
22b. LICENSE NUMBER: 10527
NAME AND ADDRESS OF FACILITY: Garone FH 1830 E Somerset St Phila Pa 19134
23a. To the best of my knowledge, death occurred at the time, date and place stated. (Signature and Title): Aurelle Jones MD
23b. LICENSE NUMBER: MD039827-L
23c. DATE SIGNED: January 25, 2005
24. TIME OF DEATH: 3:48 A.M.
25. DATE PRONOUNCED DEAD: January 25, 2005
26. WAS CASE REFERRED TO A MEDICAL EXAMINER / CORONER? No

27. PART I: Enter the diseases, injuries or complications which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Cardiorespiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c. acute colitis
DUE TO (OR AS A CONSEQUENCE OF):
d. Abdominal obstruction

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.

PART II: Other significant conditions contributing to death, but not resulting in the underlying cause given in PART I
Ca of the larynx
HIV sero positive
Hepatitis C

28a. WAS AN AUTOPSY PERFORMED? No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? No
29. MANNER OF DEATH: Natural
30a. DATE OF INJURY
30b. TIME OF INJURY
30c. INJURY AT WORK? No
30d. DESCRIBE HOW INJURY OCCURRED
30e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)
30f. LOCATION (Street, City/Town, State)

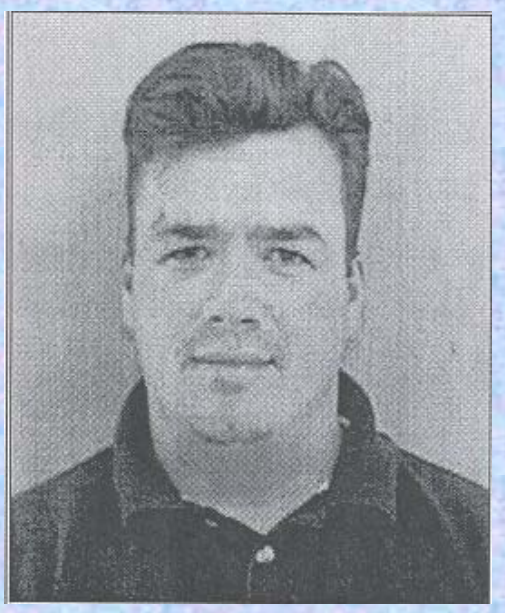
CERTIFIER (Check only one)
"CERTIFYING PHYSICIAN" (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
"PRONOUNCING AND CERTIFYING PHYSICIAN" (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. [X]
"MEDICAL EXAMINER/CORONER" 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.

31a. SIGNATURE AND TITLE OF CERTIFIER: Aurelle Jones MD
31b. LICENSE NUMBER: MD039827-L
31c. DATE SIGNED: January 25, 2005
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) Type or Print: Aurelle Jones, MD NEH 2301 Allegheny Ave Philadelphia PA.
33. REGISTRAR'S SIGNATURE AND NUMBER: Wilfred J. DeRosa - 51001
34. DATE FILED: JAN 28 2005

Joseph Pace's official death certificate. His causes of death include: sepsis, acute colitis, and abdominal obstruction. Contributing conditions are listed: cancer of the larynx, HIV sero positive, and hepatitis C. The real date and time of death are recorded as January 25 2005, at 3:48 am.

James McCafferty Funeral Home

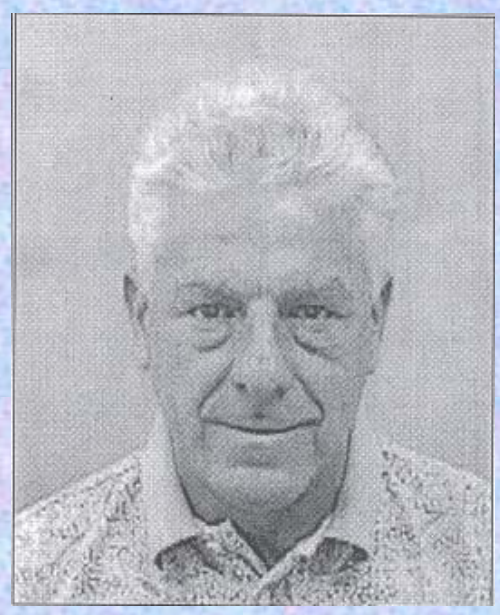
Home



Garzone Funeral Home (Gerald Garzone)

Home

Louis A. Garzone Funeral Home



Next

Home

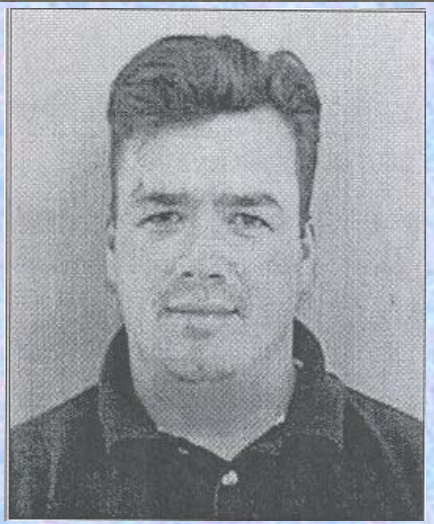
Embalming Room

Casket in Alley Way

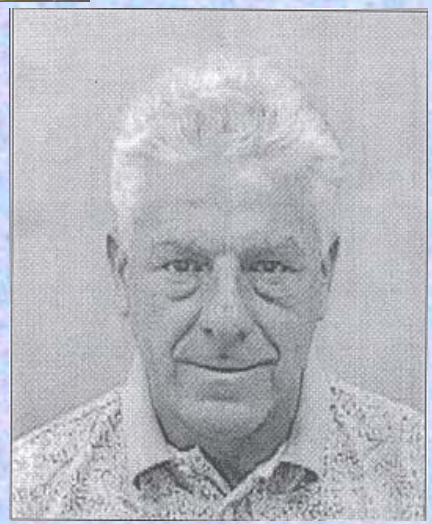
Liberty Crematory

Home

Gerald Garzone



James McCafferty



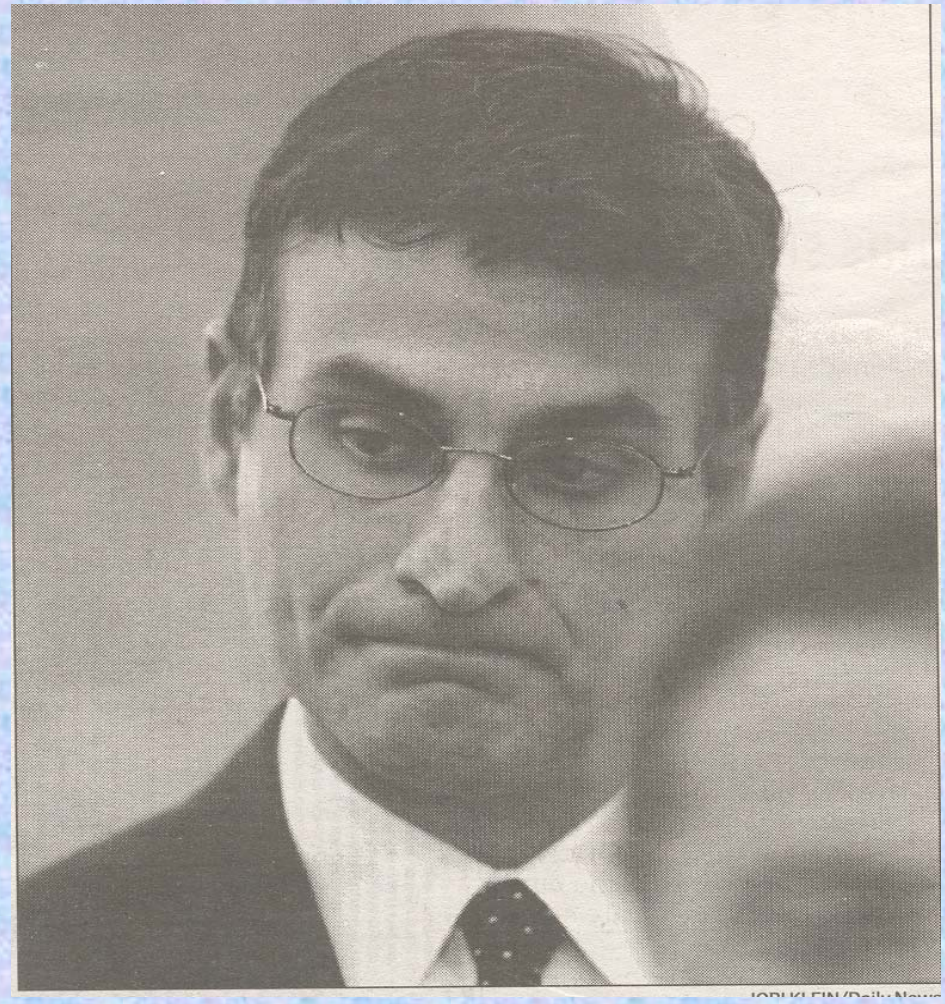
Louis Garzone

BTS

Biomedical Tissue Services

Michael Mastromarino

CEO & Executive Director of Operations

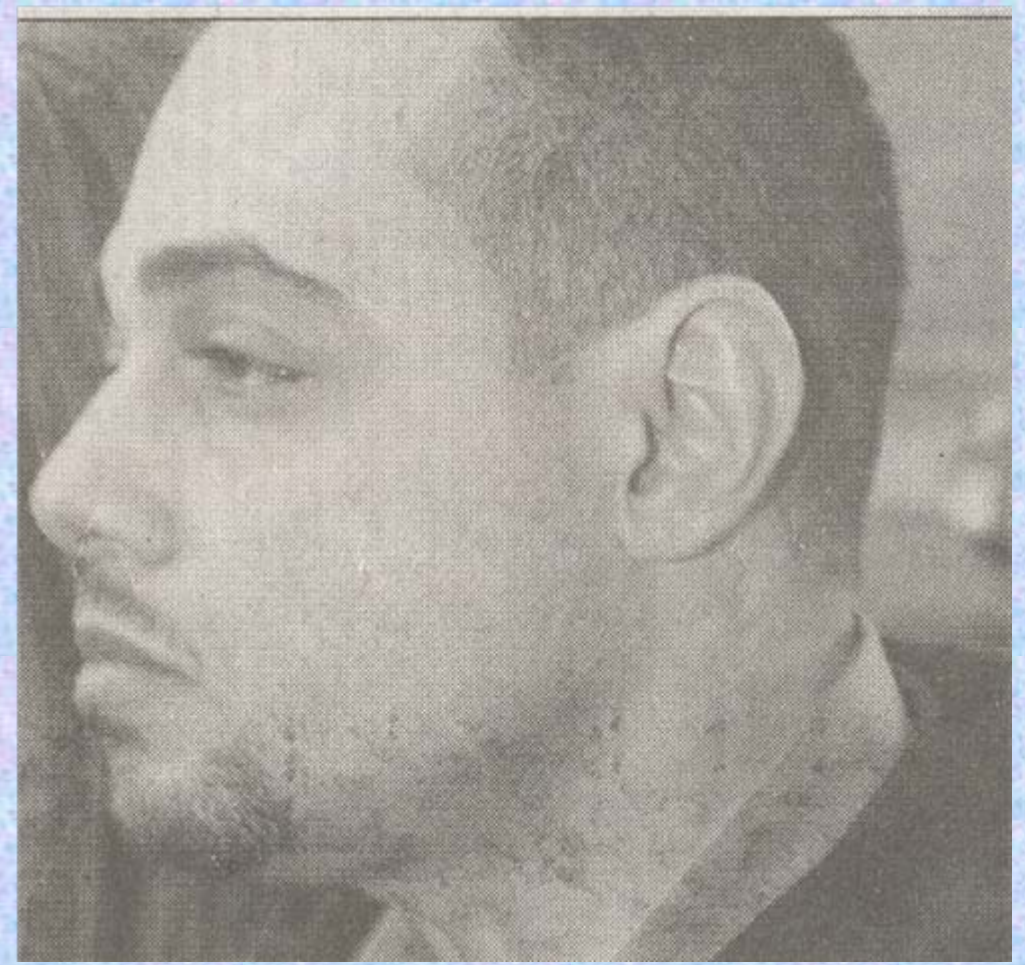


HOME

Next

BTS(cont.)

Lee Cruceta

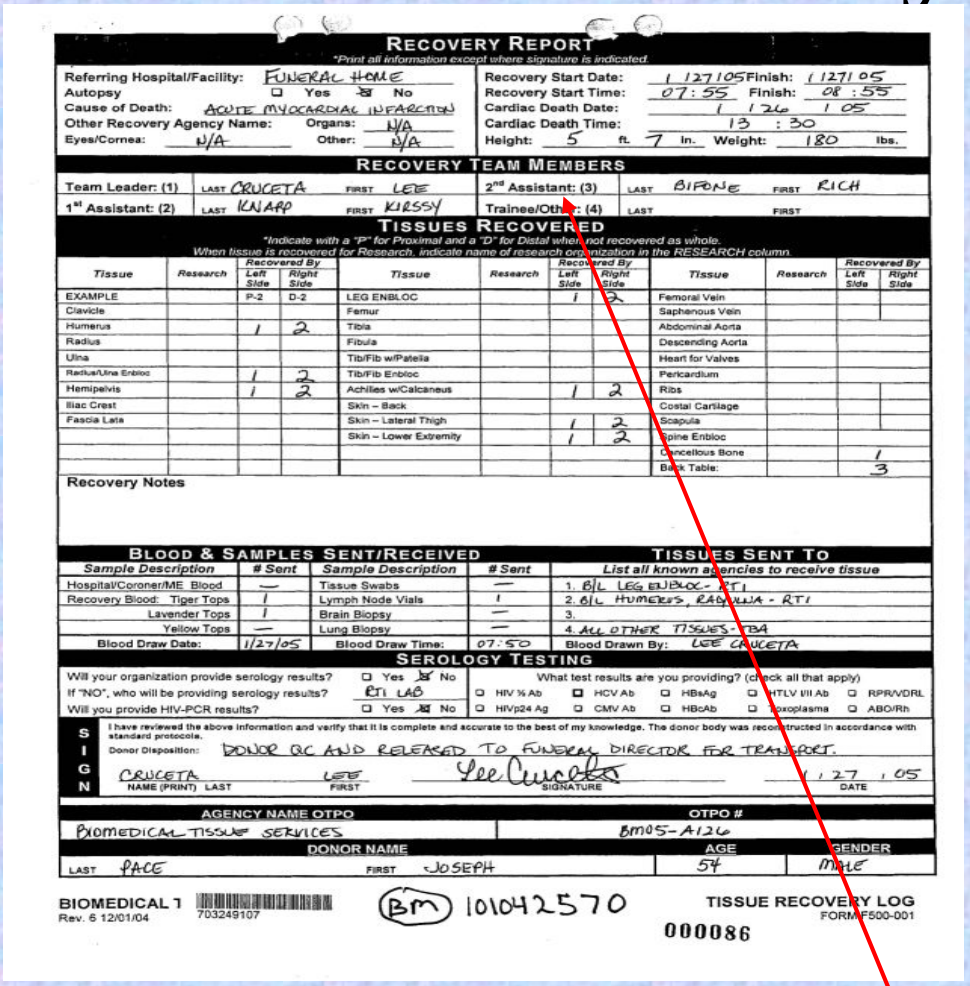


Next

BTS(cont.)

HOME

Recovery Report



RECOVERY REPORT

*"Print all information except where signature is indicated.

Referring Hospital/Facility: FUNERAL HOME
Autopsy ☐ Yes ☒ No
Cause of Death: ACUTE MYOCARDIAL INFARCTION
Other Recovery Agency Name: Organs: N/A
Eyes/Cornea: N/A Other: N/A

Recovery Start Date: 1 127 105 Finish: 1 127 105
Recovery Start Time: 07:55 Finish: 08:55
Cardiac Death Date: 1 126 1 05
Cardiac Death Time: 13:30
Height: 5 ft. 7 in. Weight: 180 lbs.

RECOVERY TEAM MEMBERS

Team Leader: (1)	LAST CRUCETA	FIRST LEE	2nd Assistant: (3)	LAST BIFONE	FIRST RICH
1st Assistant: (2)	LAST KNARP	FIRST KIRSSY	Trainee/Other: (4)	LAST	FIRST

TISSUES RECOVERED

*"Indicate with a "P" for Proximal and a "D" for Distal when not recovered as whole.
When tissue is recovered for Research, indicate name of research organization in the RESEARCH column.

Tissue	Research	Recovered By Left Side	Recovered By Right Side	Tissue	Research	Recovered By Left Side	Recovered By Right Side	Tissue	Research	Recovered By Left Side	Recovered By Right Side
EXAMPLE		P-2	D-2	LEG ENBLOC		1	2	Femoral Vein			
Clavicle				Femur				Saphenous Vein			
Humerus		1	2	Tibia				Abdominal Aorta			
Radius				Fibula				Descending Aorta			
Ulna				Tib/Fib w/Patella				Heart for Valves			
Radius/Ulna Enbloc		1	2	Tib/Fib Enbloc				Pericardium			
Hemipelvis		1	2	Achilles w/Calcaneus		1	2	Ribs			
Iliac Crest				Skin – Back				Costal Cartilage			
Fascia Lata				Skin – Lateral Thigh		1	2	Scapula			
				Skin – Lower Extremity		1	2	Spine Enbloc			
								Cancellous Bone		1	
								Back Table:		3	

Recovery Notes

BLOOD & SAMPLES SENT/RECEIVED

Sample Description	# Sent	Sample Description	# Sent
Hospital/Coroner/ME Blood	—	Tissue Swabs	—
Recovery Blood: Tiger Tops	1	Lymph Node Vials	1
Lavender Tops	1	Brain Biopsy	—
Yellow Tops	—	Lung Biopsy	—
Blood Draw Date:	1/27/05	Blood Draw Time:	07:50

TISSUES SENT TO

List all known agencies to receive tissue

1. B/L LEG ENBLOC - RTI
2. B/L HUMERUS, RADIUS/ULNA - RTI
3.
4. ALL OTHER TISSUES - TBA

Blood Drawn By: LEE CRUCETA

SEROLOGY TESTING

Will your organization provide serology results? ☐ Yes ☒ No
If "NO", who will be providing serology results? RTI LAB
Will you provide HIV-PCR results? ☐ Yes ☒ No

What test results are you providing? (check all that apply)
☐ HIV ½ Ab ☐ HCV Ab ☐ HBsAg ☐ HTLV I/II Ab ☐ RPR/VDRL
☐ HIVp24 Ag ☐ CMV Ab ☐ HBcAb ☐ Toxoplasma ☐ ABO/Rh

SIGN: I have reviewed the above information and verify that it is complete and accurate to the best of my knowledge. The donor body was reconstructed in accordance with standard protocols.
Donor Disposition: DONOR RC AND RELEASED TO FUNERAL DIRECTOR FOR TRANSPORT.
CRUCETA (NAME (PRINT) LAST) LEE (FIRST) Lee Cruceta (SIGNATURE) 1 127 105 (DATE)

AGENCY NAME OTPO	OTPO #
BIOMEDICAL TISSUE SERVICES	BM05-A126

DONOR NAME		AGE	GENDER
LAST PACE	FIRST JOSEPH	54	MALE

BIOMEDICAL 1 Rev. 6 12/01/04 703249107 BM 101042570 TISSUE RECOVERY LOG FORM F500-001

000086

As team leader, Cruceta filled out recovery reports that recorded when a recovery took place, who participated, and what tissues were taken. On these reports, he routinely lied about the real time of death.

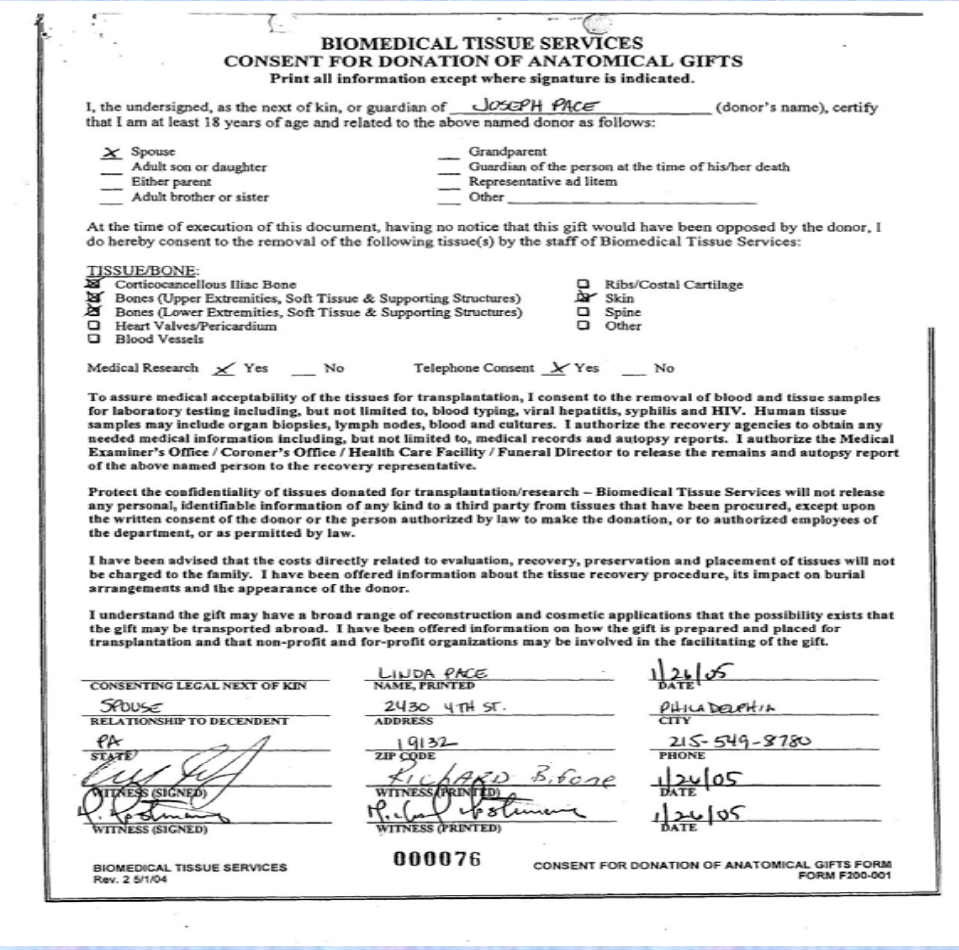
RECOVERY TEAM MEMBERS

Team Leader: (1)	LAST CRUCETA	FIRST LEE	2nd Assistant: (3)	LAST BIFONE	FIRST RICH
1st Assistant: (2)	LAST KNARP	FIRST KIRSSY	Trainee/Other: (4)	LAST	FIRST

Tissue Banks

Consent Forms

Next



BIOMEDICAL TISSUE SERVICES
CONSENT FOR DONATION OF ANATOMICAL GIFTS
Print all information except where signature is indicated.

I, the undersigned, as the next of kin, or guardian of JOSEPH PACE (donor's name), certify that I am at least 18 years of age and related to the above named donor as follows:

- [X] Spouse
- [ ] Adult son or daughter
- [ ] Either parent
- [ ] Adult brother or sister
- [ ] Grandparent
- [ ] Guardian of the person at the time of his/her death
- [ ] Representative ad litem
- [ ] Other

At the time of execution of this document, having no notice that this gift would have been opposed by the donor, I do hereby consent to the removal of the following tissue(s) by the staff of Biomedical Tissue Services:

TISSUE/BONE:

- [X] Corticocancellous Iliac Bone
- [X] Bones (Upper Extremities, Soft Tissue & Supporting Structures)
- [X] Bones (Lower Extremities, Soft Tissue & Supporting Structures)
- [ ] Heart Valves/Pericardium
- [ ] Blood Vessels
- [ ] Ribs/Costal Cartilage
- [X] Skin
- [ ] Spine
- [ ] Other

Medical Research [X] Yes [ ] No Telephone Consent [X] Yes [ ] No

To assure medical acceptability of the tissues for transplantation, I consent to the removal of blood and tissue samples for laboratory testing including, but not limited to, blood typing, viral hepatitis, syphilis and HIV. Human tissue samples may include organ biopsies, lymph nodes, blood and cultures. I authorize the recovery agencies to obtain any needed medical information including, but not limited to, medical records and autopsy reports. I authorize the Medical Examiner's Office / Coroner's Office / Health Care Facility / Funeral Director to release the remains and autopsy report of the above named person to the recovery representative.

Protect the confidentiality of tissues donated for transplantation/research – Biomedical Tissue Services will not release any personal, identifiable information of any kind to a third party from tissues that have been procured, except upon the written consent of the donor or the person authorized by law to make the donation, or to authorized employees of the department, or as permitted by law.

I have been advised that the costs directly related to evaluation, recovery, preservation and placement of tissues will not be charged to the family. I have been offered information about the tissue recovery procedure, its impact on burial arrangements and the appearance of the donor.

I understand the gift may have a broad range of reconstruction and cosmetic applications that the possibility exists that the gift may be transported abroad. I have been offered information on how the gift is prepared and placed for transplantation and that non-profit and for-profit organizations may be involved in the facilitating of the gift.

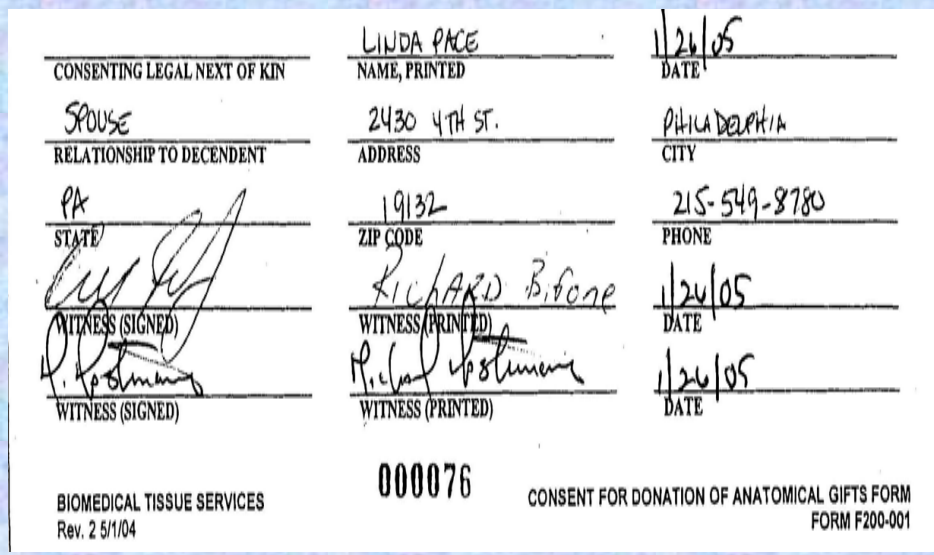
CONSENTING LEGAL NEXT OF KIN	LINDA PACE (NAME, PRINTED)	1/26/05 (DATE)
SPOUSE (RELATIONSHIP TO DECENDENT)	2430 4TH ST. (ADDRESS)	PHILADELPHIA (CITY)
PA (STATE)	19132 (ZIP CODE)	215-549-8780 (PHONE)
WITNESS (SIGNED)	RICHARD B. BOSE (WITNESS (PRINTED))	1/26/05 (DATE)
WITNESS (SIGNED)	WITNESS (PRINTED)	1/26/05 (DATE)

BIOMEDICAL TISSUE SERVICES
Rev. 2 5/1/04

000076

CONSENT FOR DONATION OF ANATOMICAL GIFTS FORM
FORM F200-001

Consent form signed by Michael Mastromarino and Richard Bifone. They purport to witness a spouse's consent to donate Joseph Pace's body parts. The alleged spouse, "Linda Pace," is not a real person. Mastromarino had Bifone sign stacks of blank consent forms and would fill the names in later.



CONSENTING LEGAL NEXT OF KIN	LINDA PACE (NAME, PRINTED)	1/26/05 (DATE)
SPOUSE (RELATIONSHIP TO DECENDENT)	2430 4TH ST. (ADDRESS)	PHILADELPHIA (CITY)
PA (STATE)	19132 (ZIP CODE)	215-549-8780 (PHONE)
WITNESS (SIGNED)	RICHARD B. BOSE (WITNESS (PRINTED))	1/26/05 (DATE)
WITNESS (SIGNED)	WITNESS (PRINTED)	1/26/05 (DATE)

BIOMEDICAL TISSUE SERVICES
Rev. 2 5/1/04

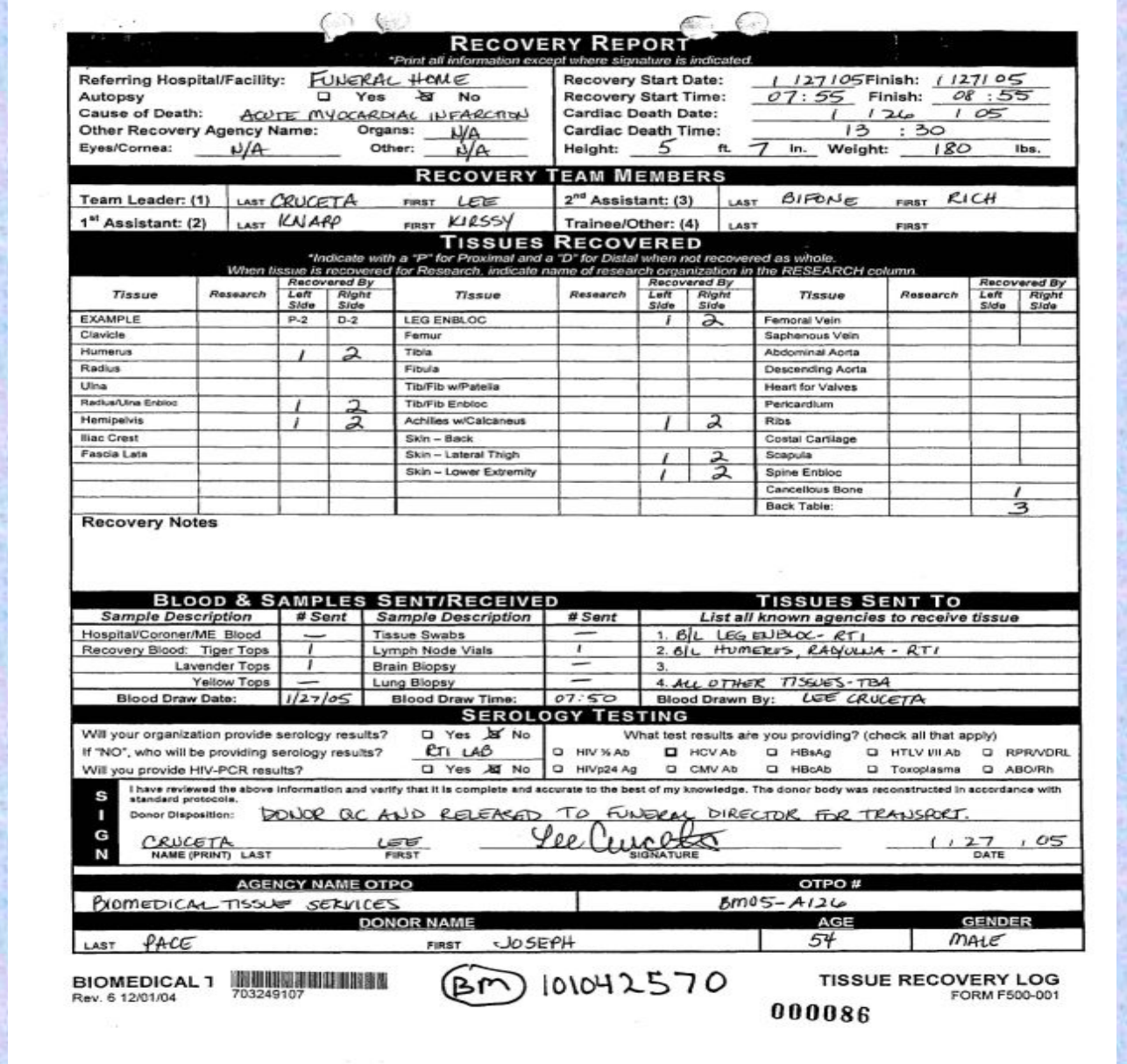
000076

CONSENT FOR DONATION OF ANATOMICAL GIFTS FORM
FORM F200-001

Tissue Banks

Next

Recovery Report



RECOVERY REPORT

*Print all information except where signature is indicated.

Referring Hospital/Facility: FUNERAL HOME
Autopsy ☐ Yes ☒ No
Cause of Death: ACUTE MYOCARDIAL INFARCTION
Other Recovery Agency Name: Organs: N/A
Eyes/Cornea: N/A Other: N/A

Recovery Start Date: 1/27/05 Finish: 1/27/05
Recovery Start Time: 07:55 Finish: 08:55
Cardiac Death Date: 1/26/05
Cardiac Death Time: 13:30
Height: 5 ft. 7 in. Weight: 180 lbs.

RECOVERY TEAM MEMBERS

Team Leader: (1)	LAST CRUCETA	FIRST LEE	2nd Assistant: (3)	LAST BIFONE	FIRST RICH
1st Assistant: (2)	LAST KNARP	FIRST KIRSSY	Trainee/Other: (4)	LAST	FIRST

TISSUES RECOVERED

*Indicate with a "P" for Proximal and a "D" for Distal when not recovered as whole.
When tissue is recovered for Research, indicate name of research organization in the RESEARCH column.

Tissue	Research	Recovered By Left Side	Recovered By Right Side	Tissue	Research	Recovered By Left Side	Recovered By Right Side	Tissue	Research	Recovered By Left Side	Recovered By Right Side
EXAMPLE		P-2	D-2	LEG ENBLOC		1	2	Femoral Vein			
Clavicle				Femur				Saphenous Vein			
Humerus		1	2	Tibia				Abdominal Aorta			
Radius				Fibula				Descending Aorta			
Ulna				Tib/Fib w/Patella				Heart for Valves			
Radius/Ulna Enbloc		1	2	Tib/Fib Enbloc				Pericardium			
Hemipelvis		1	2	Achilles w/Calcaneus		1	2	Ribs			
Iliac Crest				Skin – Back				Costal Cartilage			
Fascia Lata				Skin – Lateral Thigh		1	2	Scapula			
				Skin – Lower Extremity		1	2	Spine Enbloc			
								Cancellous Bone			1
								Back Table:			3

Recovery Notes

BLOOD & SAMPLES SENT/RECEIVED

Sample Description	# Sent	Sample Description	# Sent
Hospital/Coroner/ME Blood	—	Tissue Swabs	—
Recovery Blood: Tiger Tops	1	Lymph Node Vials	1
Lavender Tops	1	Brain Biopsy	—
Yellow Tops	—	Lung Biopsy	—
Blood Draw Date:	1/27/05	Blood Draw Time:	07:50

TISSUES SENT TO

List all known agencies to receive tissue

1. B/L LEG ENBLOC - RTI
2. B/L HUMERUS, RADIUS/ULNA - RTI
3.
4. ALL OTHER TISSUES - TBA

Blood Drawn By: LEE CRUCETA

SEROLOGY TESTING

Will your organization provide serology results? ☐ Yes ☒ No
If "NO", who will be providing serology results? RTI LAB
Will you provide HIV-PCR results? ☐ Yes ☒ No

What test results are you providing? (check all that apply)
☐ HIV ½ Ab ☐ HCV Ab ☐ HBsAg ☐ HTLV I/II Ab ☐ RPR/VDRL
☐ HIVp24 Ag ☐ CMV Ab ☐ HBcAb ☐ Toxoplasma ☐ ABO/Rh

SIGN

I have reviewed the above information and verify that it is complete and accurate to the best of my knowledge. The donor body was reconstructed in accordance with standard protocols.

Donor Disposition: DONOR RC AND RELEASED TO FUNERAL DIRECTOR FOR TRANSPORT.

CRUCETA (NAME (PRINT) LAST) LEE (FIRST) Lee Cruceta (SIGNATURE) 1/27/05 (DATE)

AGENCY NAME OTPO	OTPO #
BIOMEDICAL TISSUE SERVICES	BM05-A126

DONOR NAME		AGE	GENDER
LAST PACE	FIRST JOSEPH	54	MALE

BIOMEDICAL 1 Rev. 6 12/01/04 703249107 BM 101042570 TISSUE RECOVERY LOG FORM F500-001

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Official Death Certificate

Next

(Rev 3/87)

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

009495

CERTIFICATE OF DEATH

STATE FILE NUMBER

1. NAME OF DECEDENT (First, Middle, Last): Joseph B. Pace
2. SEX: Male
3. SOCIAL SECURITY NUMBER: [redacted]
4. DATE OF DEATH (Month, Day, Year): January 25, 2005
5. AGE (Last Birthday): 54 Yrs
6. UNDER 1 YEAR: Months / Days
7. UNDER 1 DAY: Hours / Minutes
8. DATE OF BIRTH (Month, Day, Year): [redacted]
9. BIRTHPLACE (City and State/Foreign Country): Phila PA
10. PLACE OF DEATH (Check only one - see instructions on other side): Hospital ☒ ER/Outpatient ☐ DOA ☐ Other: Nursing Home ☐ Residence ☐ Other (Specify) ☐
11. COUNTY OF DEATH: Phila
12. CITY, BORO, TWP OF DEATH: Phila
13. FACILITY NAME (If not institution, give street and number): Northeastern
14. WAS DECEDENT OF HISPANIC ORIGIN? No ☒ Yes ☐ If yes, specify Cuban, Mexican, Puerto Rican, etc.
15. RACE - American Indian, Black, White, etc.: White
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, do not use retired): SUPERVISOR
17. KIND OF BUSINESS / INDUSTRY: Phila Water Co
18. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes ☐ No ☒
19. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):
20. MARITAL STATUS - Married, Never Married, Widowed, Divorced: W
21. SURVIVING SPOUSE (If wife, give maiden name):
22. DECEDENT'S MAILING ADDRESS (Street, City/Town, State, Zip Code): 2009 E Allegheny Ave Phila PA 19134
23. DECEDENT'S ACTUAL RESIDENCE (If different than 22): 17a. State: PA; 17b. County: Phila; 17c. Did decedent live in a town/ship? ☐ Yes, decedent lived in: ; 17d. ☒ No, decedent lived within city or limits of: Phila
24. FATHER'S NAME (First, Middle, Last): Joseph Pace
25. MOTHER'S NAME (First, Middle, Maiden Surname): UKN.
26a. INFORMANT'S NAME (Type or Print): Carolyn Garcia
26b. INFORMANT'S MAILING ADDRESS (Street, City/Town, State, Zip Code): 3637 N Marshall St Phila PA 19133
27. METHOD OF DISPOSITION: Donation ☐ Burial ☐ Cremation ☒ Removal from State ☐ Other (Specify):
28. DATE OF DISPOSITION (Month, Day, Year): 1-26-05
29. PLACE OF DISPOSITION - Name of Cemetery, Crematory or Other Place: Liberty Cremation
30. LOCATION - City/Town, State, Zip Code: Phila Pa 19134
31a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Paul A. Parone
31b. LICENSE NUMBER: 10527
31c. NAME AND ADDRESS OF FACILITY: Parone FH 1830 E Somerset St Phila Pa 19134

Complete items 33a-c only when certifying physician is not available at time of death to certify cause of death

32a. To the best of my knowledge, death occurred at the time, date and place stated. (Signature and Title): Aurelle Jones MD
32b. LICENSE NUMBER: MD039827-L
32c. DATE SIGNED (Month, Day, Year): January 25, 2005
32d. TIME OF DEATH: 3:48 AM
32e. DATE PRONOUNCED DEAD (Month, Day, Year): January 25, 2005
32f. WAS CASE REFERRED TO A MEDICAL EXAMINER/CORONER? Yes ☐ No ☒

Items 34-36 must be completed by person who pronounces death

37. PART I: Enter the diseases, injuries or complications which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiorespiratory Failure
DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF): c. acute colitis
DUE TO (OR AS A CONSEQUENCE OF): d. Abdominal obstruction

Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate interval between onset and death:

PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in PART I: Ca of the larynx; HIV sero positive; Hepatitis C

38a. WAS AN AUTOPSY PERFORMED? Yes ☐ No ☒
38b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes ☐ No ☒
39. MANNER OF DEATH: Natural ☒ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined ☐
40a. DATE OF INJURY (Month, Day, Year):
40b. TIME OF INJURY:
40c. INJURY AT WORK? Yes ☐ No ☐
40d. DESCRIBE HOW INJURY OCCURRED:
40e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify):
40f. LOCATION (Street, City/Town, State):

41. CERTIFIER (Check only one)

"CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 33) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. ☐

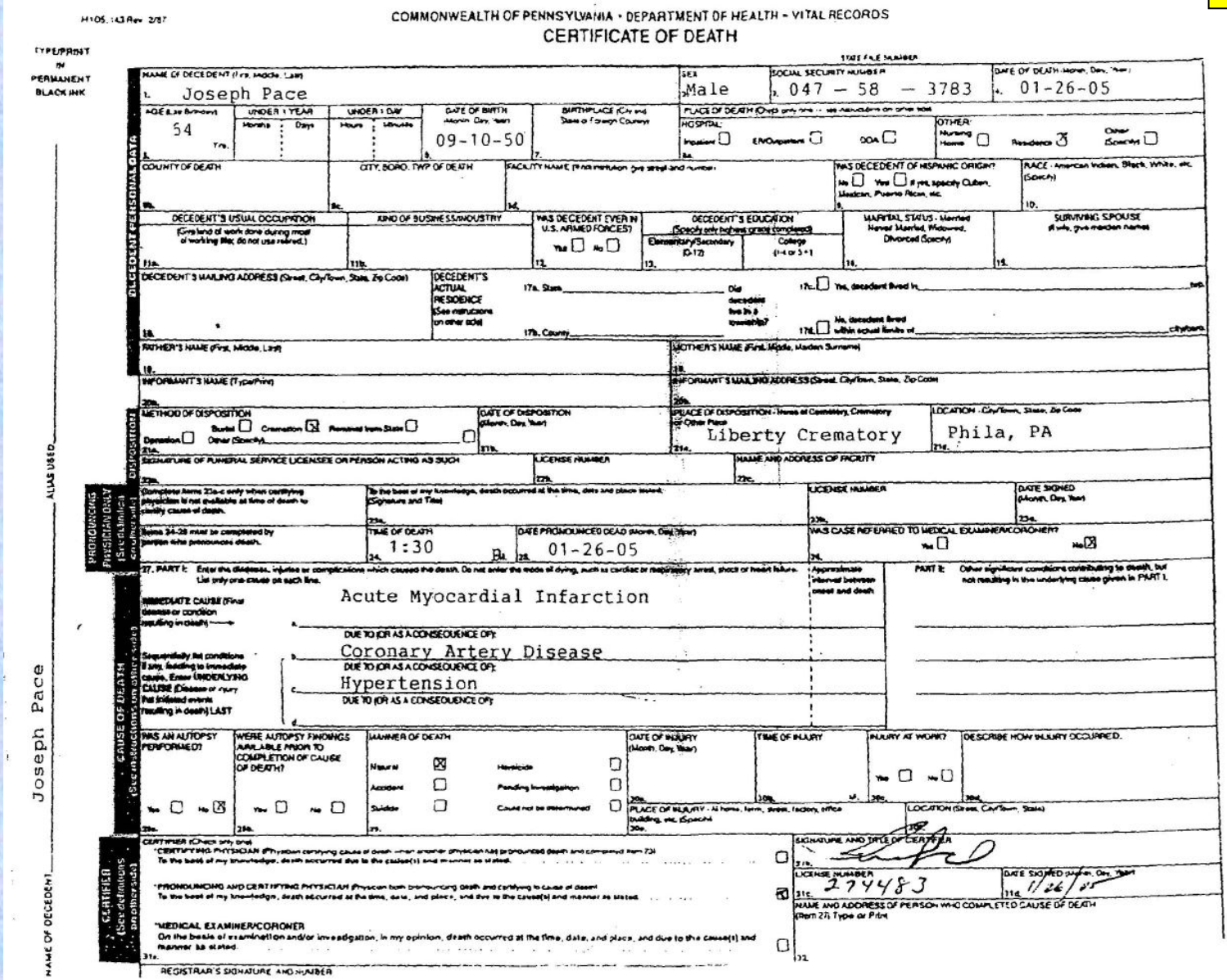
"PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. ☒

"MEDICAL EXAMINER/CORONER 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. ☐

41a. SIGNATURE AND TITLE OF CERTIFIER: Aurelle Jones MD
41b. LICENSE NUMBER: MD039827-L
41c. DATE SIGNED (Month, Day, Year): January 25, 2005
42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 37) Type or Print: Aurelle Jones, MD NEH 2301 Allegheny Ave Philadelphia PA.
43. REGISTRAR'S SIGNATURE AND NUMBER: William J. DiRosa - 51001
44. DATE FILED (Month, Day, Year): JAN 28 2005

Fraudulent Death Certificate

HOME



H105.143 Rev. 2/87

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

STATE FILE NUMBER

DECEDENT PERSONAL DATA

1. NAME OF DECEDENT (First, Middle, Last): Joseph Pace
2. SEX: Male
3. SOCIAL SECURITY NUMBER: 047 – 58 – 3783
4. DATE OF DEATH (Month, Day, Year): 01-26-05
5. AGE (Last Birthday): 54 Yrs.
6. UNDER 1 YEAR: Months / Days
7. UNDER 1 DAY: Hours / Minutes
8. DATE OF BIRTH (Month, Day, Year): 09-10-50
9. BIRTHPLACE (City and State or Foreign Country)
10. PLACE OF DEATH (Check only one – see instructions on other side): HOSPITAL: Inpatient ☐ ER/Outpatient ☐ DOA ☐ OTHER: Nursing Home ☐ Residence ☒ Other (Specify) ☐
11. COUNTY OF DEATH
12. CITY, BORO, TWP OF DEATH
13. FACILITY NAME (If not institution, give street and number)
14. WAS DECEDENT OF HISPANIC ORIGIN? No ☐ Yes ☐ If yes, specify Cuban, Mexican, Puerto Rican, etc.
15. RACE – American Indian, Black, White, etc. (Specify)
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life; do not use retired.)
17. KIND OF BUSINESS/INDUSTRY
18. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes ☐ No ☐
19. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
20. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)
21. SURVIVING SPOUSE (If wife, give maiden name)
22. DECEDENT'S MAILING ADDRESS (Street, City/Town, State, Zip Code)
23. DECEDENT'S ACTUAL RESIDENCE (See instructions on other side) 23a. State 23b. County 23c. Did decedent live in a township? ☐ Yes, decedent lived in 23d. ☐ No, decedent lived within school limits of
24. FATHER'S NAME (First, Middle, Last)
25. MOTHER'S NAME (First, Middle, Maiden Surname)
26. INFORMANT'S NAME (Type/Print)
27. INFORMANT'S MAILING ADDRESS (Street, City/Town, State, Zip Code)

DISPOSITION

28. METHOD OF DISPOSITION: Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify) ☐
29. DATE OF DISPOSITION (Month, Day, Year)
30. PLACE OF DISPOSITION – Name of Cemetery, Crematory or Other Place: Liberty Crematory
31. LOCATION – City/Town, State, Zip Code: Phila, PA
32. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
33. LICENSE NUMBER
34. NAME AND ADDRESS OF FACILITY

PRONOUNCING PHYSICIAN ONLY (Specify/Initial)

35. Complete items 35a-c only when certifying physician is not available at time of death to identify cause of death.
35a. To the best of my knowledge, death occurred at the time, date and place stated. (Signature and Title)
35b. LICENSE NUMBER
35c. DATE SIGNED (Month, Day, Year)
36. Items 36-38 must be completed by person who pronounces death. TIME OF DEATH: 1:30 ☒ PM
37. DATE PRONOUNCED DEAD (Month, Day, Year): 01-26-05
38. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes ☐ No ☒

CAUSE OF DEATH (See instructions on other side)

39. PART I: Enter the diseases, injuries or complications which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF): d.
Approximate interval between onset and death
PART II: Other significant conditions contributing to death, but not resulting in the underlying cause given in PART I.
40. WAS AN AUTOPSY PERFORMED? Yes ☐ No ☒
41. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes ☐ No ☐
42. MANNER OF DEATH: Natural ☒ / Homicide ☐ / Accident ☐ / Pending Investigation ☐ / Suicide ☐ / Could not be determined ☐
43. DATE OF INJURY (Month, Day, Year)
44. TIME OF INJURY
45. INJURY AT WORK? Yes ☐ No ☐
46. DESCRIBE HOW INJURY OCCURRED.
47. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (Specify)
48. LOCATION (Street, City/Town, State)

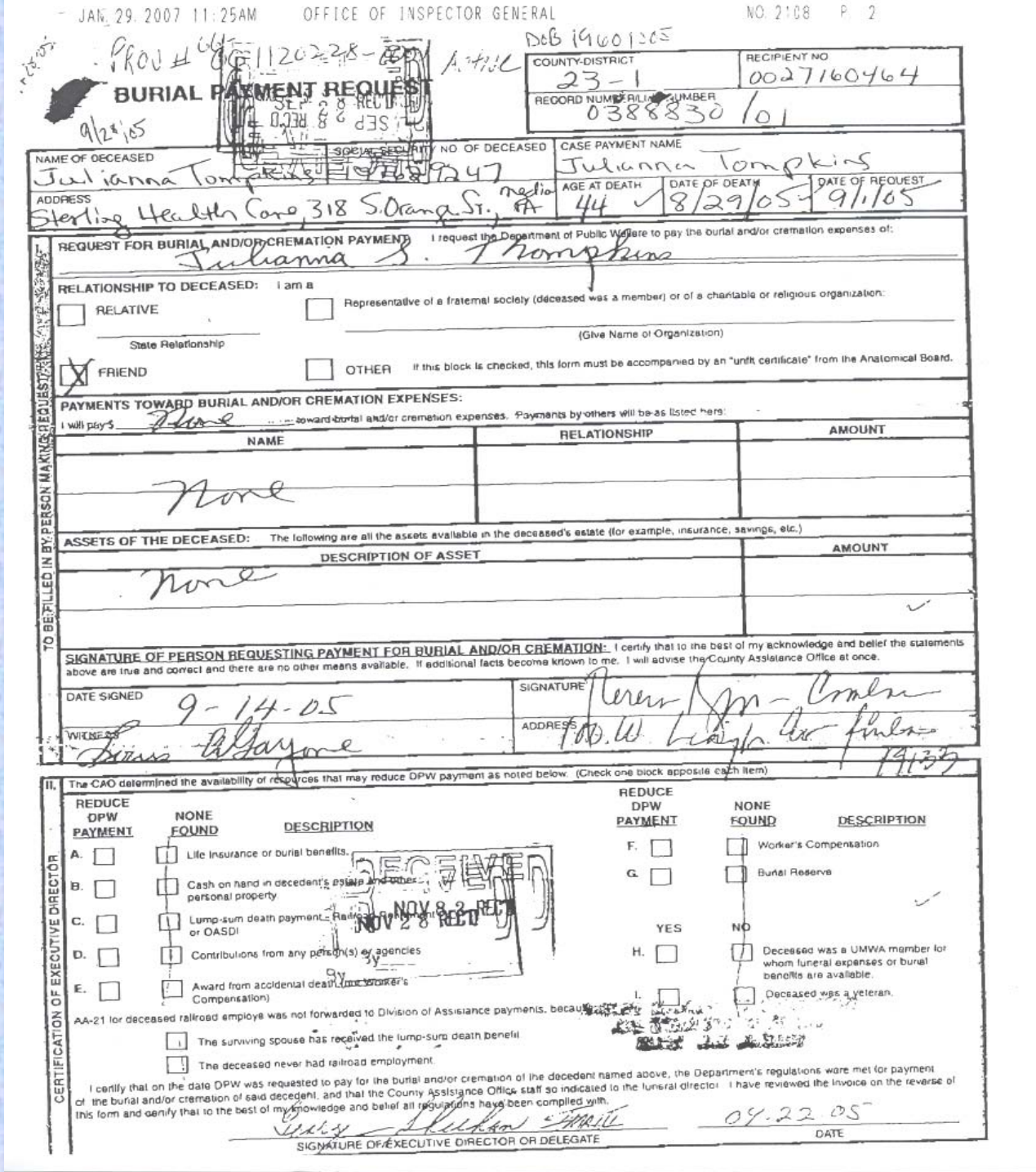
CERTIFIER (See definitions on other side)

49. CERTIFIER (Check only one)
☐ *CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 35) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☒ *PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ *MEDICAL EXAMINER/CORONER 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.
49a. SIGNATURE AND TITLE OF CERTIFIER
49b. LICENSE NUMBER: 274483
49c. DATE SIGNED (Month, Day, Year): 1/26/05
49d. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) Type or Print
50. REGISTRAR'S SIGNATURE AND NUMBER

ALIAS USED

NAME OF DECEDENT: Joseph Pace

760000



JAN. 29. 2007 11:25AM OFFICE OF INSPECTOR GENERAL NO. 2108 P. 2

PROV # 06112022-8 DOB 19601205

BURIAL PAYMENT REQUEST

SEP 28 REC'D

COUNTY-DISTRICT	RECIPIENT NO
23-1	0027160464

RECORD NUMBER/CLAIM NUMBER 0388830 / 01

NAME OF DECEASED	SOCIAL SECURITY NO. OF DECEASED	CASE PAYMENT NAME
Julianna Tompkins	1968 9247	Julianna Tompkins

ADDRESS	AGE AT DEATH	DATE OF DEATH	DATE OF REQUEST
Sterling Health Care, 318 S. Orange St., Media PA	44	8/29/05	9/1/05

REQUEST FOR BURIAL AND/OR CREMATION PAYMENT: I request the Department of Public Welfare to pay the burial and/or cremation expenses of: Julianna S. Thompkins

RELATIONSHIP TO DECEASED: I am a

☐ RELATIVE — State Relationship

☐ Representative of a fraternal society (deceased was a member) or of a charitable or religious organization: (Give Name of Organization)

☒ FRIEND

☐ OTHER — If this block is checked, this form must be accompanied by an "unfit certificate" from the Anatomical Board.

PAYMENTS TOWARD BURIAL AND/OR CREMATION EXPENSES:

I will pay $ None toward burial and/or cremation expenses. Payments by others will be as listed here:

NAME	RELATIONSHIP	AMOUNT
None		

ASSETS OF THE DECEASED: The following are all the assets available in the deceased's estate (for example, insurance, savings, etc.)

DESCRIPTION OF ASSET	AMOUNT
None	

SIGNATURE OF PERSON REQUESTING PAYMENT FOR BURIAL AND/OR CREMATION: I certify that to the best of my acknowledge and belief the statements above are true and correct and there are no other means available. If additional facts become known to me, I will advise the County Assistance Office at once.

DATE SIGNED 9-14-05 SIGNATURE [signature]

WITNESS Louis Garzone ADDRESS 108 W Lincoln Ave Folsom PA 19033

TO BE FILLED IN BY PERSON MAKING REQUEST

II. CERTIFICATION OF EXECUTIVE DIRECTOR

The CAO determined the availability of resources that may reduce DPW payment as noted below. (Check one block opposite each item)

	REDUCE DPW PAYMENT	NONE FOUND	DESCRIPTION
A.	☐	☐	Life insurance or burial benefits.
B.	☐	☐	Cash on hand in decedent's estate and other personal property
C.	☐	☐	Lump-sum death payment - Railroad Retirement Act or OASDI
D.	☐	☐	Contributions from any person(s) or agencies
E.	☐	☐	Award from accidental death (not Worker's Compensation)
F.	☐	☐	Worker's Compensation
G.	☐	☐	Burial Reserve

RECEIVED NOV 8 2 REC'D NOV 28 REC'D

	YES	NO	
H.	☐	☐	Deceased was a UMWA member for whom funeral expenses or burial benefits are available.
I.	☐	☐	Deceased was a veteran.

AA-21 for deceased railroad employe was not forwarded to Division of Assistance payments, because

☐ The surviving spouse has received the lump-sum death benefit

☐ The deceased never had railroad employment.

I certify that on the date DPW was requested to pay for the burial and/or cremation of the decedent named above, the Department's regulations were met for payment of the burial and/or cremation of said decedent, and that the County Assistance Office staff so indicated to the funeral director. I have reviewed the invoice on the reverse of this form and certify that to the best of my knowledge and belief all regulations have been complied with.

[signature] 09.22.05

SIGNATURE OF EXECUTIVE DIRECTOR OR DELEGATE — DATE

HOME

Louis Garzone falsely certified on this DPW burial request form (PA118) that he had received no payment toward Juliana Thompkins' funeral. In fact, her relatives had paid $1000. As a result of this fraudulent claim, DPW paid Garzone $750.

Next

JAN. 29. 2007 11:25AM OFFICE OF INSPECTOR GENERAL NO. 2108 P. 3

INVOICE TO:
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF INCOME MAINTENANCE

*TO BE COMPLETED BY FUNERAL DIRECTOR

BURIAL/CREMATION CHARGES FOR: Julianna S. Tompkins — DECEASED
CEMETERY WHERE BURIED: Liberty Cremetory — CITY: Phila PA — DATE OF BURIAL: 8.30.05

1. Maximum payment allowance requested from DPW for burial and/or cremation ($750.00 per deceased person). $750 00

2. Resources that reduce DPW payment
Resources applicable to cost of burial and/or cremation.

CROSBY DISTRICT SEP 16 2005

RESOURCE	AMOUNT
None	

Resources that will reduce DPW payment — TOTAL = $ —

3. Contributions that may reduce DPW payment from friends, relatives, other entities, i.e. Fraternal organizations, etc.

CONTRIBUTOR	AMOUNT
None	—
TOTAL CONTRIBUTIONS	

$ —

Excess = Total contributions minus $750.00 per deceased person.

4. Total resources and/or contributions (excess over $750.00 per deceased person) that will reduce DPW payment. If total is 0 or less, enter 0. $ 0 $ 0

5. DPW payment owing after reduction for resources and/or contributions exceeding $750.00 per deceased person ($750.00 per deceased person, minus item 4). $ 750 00

6. **Total DPW payment to funeral service provider (item 5 repeated).** $750 00

CERTIFICATION OF FUNERAL DIRECTOR

I certify that the amount listed in Item 5 constitutes the entire bill incidental to the burial/cremation of the person named above, that no payment has been, or will be, accepted from any other source, and that I will notify the County Assistance Office promptly of any additional resources that come to my attention.

Louis A Garzone — SIGNATURE OF FUNERAL DIRECTOR
9.14.05 — DATE

GARZONE FUNERAL HOME
1830 E. SOMERSET ST.
PHILA. PA. 19134
FIRM NAME AND ADDRESS

0007856 88000 1

Provider MA ID Number

Provider Address Code

HOME

Louis Garzone certified that he was paid nothing and requested $750 from DPW.