

**STATE OF TEXAS**  
**CERTIFICATION OF VITAL RECORD**

**DEPARTMENT OF STATE HEALTH SERVICES**  
**VITAL STATISTICS UNIT**

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS

SEP 19 2018

**STATE OF TEXAS**

**CERTIFICATE OF DEATH**

**STATE FILE NUMBER 142-18-141363**

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS UNIT

1. LEGAL NAME OF DECEASED (Include AKA's, if any) (First, Middle, Last) <b>TRAVIS WADE NEELY</b>			(Maiden)			2. DATE OF DEATH - ACTUAL OR PRESUMED (mm-dd-yyyy) <b>SEPTEMBER 7, 2018</b>		
3. SEX <b>MALE</b>	4. DATE OF BIRTH (mm-dd-yyyy) <b>DECEMBER 15, 1995</b>	5. AGE - Last Birthday (Years) <b>22</b>	IF UNDER 1 YR Mo Days	IF UNDER 1 DAY Hours Min	6. BIRTHPLACE (City & State or Foreign Country) <b>GARLAND, TX</b>			
7. SOCIAL SECURITY NUMBER <b>639-50-9955</b>		8. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Unknown		9. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)				
10a. RESIDENCE STREET ADDRESS <b>1349 TAWAKONI DRIVE</b>			10b. APT. NO.		10c. CITY OR TOWN <b>WEST TAWAKONI</b>			
10d. COUNTY <b>HUNT</b>		10e. STATE <b>TEXAS</b>		10f. ZIP CODE <b>75474</b>		10g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
11. FATHER'S NAME PRIOR TO FIRST MARRIAGE <b>BENNY BINES</b>			12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE <b>VICKI ADELE KISSEL</b>					
13. PLACE OF DEATH (CHECK ONLY ONE) IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)								
14. COUNTY OF DEATH <b>HUNT</b>		15. CITY/TOWN, ZIP (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO) <b>WEST TAWAKONI, 75474</b>			16. FACILITY NAME (If not institution, give street address) <b>1349 TAWAKONI DRIVE</b>			
17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED <b>VICKI NEELY - MOTHER</b>			18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code) <b>1349 TAWAKONI DRIVE, WEST TAWAKONI, TX 75474</b>					
19. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from state <input type="checkbox"/> Other (Specify)		20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH <b>JOHN M. INGRAM, BY ELECTRONIC SIGNATURE - 7743</b>			21. <input checked="" type="checkbox"/> Unknown Section _____ Block _____ Lot _____ Space _____			
22. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) <b>ABBA CREMATION AND MORTUARY SERVICE</b>		23. LOCATION (City/Town, and State) <b>QUINLAN, TX</b>						
24. NAME OF FUNERAL FACILITY <b>INGRAM FUNERAL HOME</b>		25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) <b>P O BOX 2218 /1462 EAST QUINLAN PKWY, QUINLAN, TX 75474</b>						
26. 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 checked="" type="checkbox"/> Medical Examiner/Justice of the Peace - 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.								
27. SIGNATURE OF CERTIFIER <b>WAYNE MONEY, BY ELECTRONIC SIGNATURE</b>			28. DATE CERTIFIED (mm-dd-yyyy) <b>SEPTEMBER 12, 2018</b>		29. LICENSE NUMBER		30. TIME OF DEATH (Actual or presumed) <b>10:40 PM</b>	
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) <b>WAYNE MONEY 2801 STUART STREET STE 409, GREENVILLE, TX 75401</b>					32. TITLE OF CERTIFIER <b>JP</b>			
33. PART 1. ENTER THE CHAIN OF EVENTS - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE DEATH. <b>DO NOT</b> ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON EACH.							Approximate Interval Onset to death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <b>SUICIDE</b> Due to (or as a consequence of):							<b>UNKNOWN</b>	
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.								
PART 2. ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1. <b>UNKNOWN</b>					34. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
					35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
36. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		38. 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		39. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		
40a. DATE OF INJURY (mm-dd-yyyy) <b>SEPTEMBER 7, 2018</b>		40b. TIME OF INJURY <b>10:40 PM</b>	40c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		40d. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) <b>RESIDENCE</b>			
40e. LOCATION (Street and Number, City, State, Zip Code) <b>1349 TAWAKONI DR, WEST TAWAKONI, TX 75474</b>					40f. COUNTY OF INJURY <b>HUNT</b>			
41. DESCRIBE HOW INJURY OCCURRED <b>GUNSHOT WOUND TO THE HEAD</b>								
42a. REGISTRAR FILE NO. <b>01531</b>		42b. DATE RECEIVED BY LOCAL REGISTRAR <b>SEPTEMBER 19, 2018</b>		42c. REGISTRAR <b>REGISTRAR - HUNT COUNTY CLERK, ELECTRONICALLY FILED</b>				

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine up to \$10,000. (Health and Safety Code, Sec. 195.188B)

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VS-112 REV 1/2006



This is a true and correct reproduction of the original record as recorded in this office. Issued under authority of Section 191.051, Health and Safety Code.

ISSUED SEP 21 2018

*Tara Das*  
TARA DAS  
STATE REGISTRAR



WARNING: THIS DOCUMENT HAS A DARK BLUE BORDER AND A COLORED BACKGROUND

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE