

January 17, 1947

CASE NO.

PRE-NEED NO.

"Butch"

| | | | |
|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last, Suffix) David Franklin Adams | | 2. Sex Male | |
| 3. DATE OF BIRTH (Month, Day, Year) 1-17-47 | | 4a. AGE-Last Birthday (Years) 61 | |
| 4b. UNDER 1 YEAR Months _____ Days _____ | | 4c. UNDER 1 DAY Hours _____ Minutes _____ | |
| 5. DATE OF DEATH (Month, Day, Year) 3-16-08 | | | |
| 6. SOCIAL SECURITY NUMBER 263-80-5710 | | 7. BIRTHPLACE (City and State or Foreign Country) DeFuniak Spgs Florida | |
| 8. COUNTY OF DEATH Washington Co. | | | |
| 9. PLACE OF DEATH (Check only one) HOSPITAL: _____ Inpatient _____ Emergency Room/Outpatient _____ Dead on Arrival NON-HOSPITAL: _____ Hospice Facility _____ Nursing Home/Long Term Care Facility <input checked="" type="checkbox"/> Decedent's Home _____ Other (Specify) _____ | | | |
| 10. FACILITY NAME (If not institution, give street address) 3725 Sears Road | | 11a. CITY/TOWN OR LOCATION OF DEATH Chipley | |
| 12. MARITAL STATUS (Specify) ____ Married ____ Married, but Separated <input checked="" type="checkbox"/> Widowed ____ Divorced ____ Never Married | | 11b. INSIDE CITY LIMITS? ____ Yes <input checked="" type="checkbox"/> NO | |
| 13. SURVIVING SPOUSE'S NAME (If wife, give maiden name) ____ | | 14a. RESIDENCE - STATE FL | |
| 14b. COUNTY Washington | | 14c. CITY, TOWN, LOCATION Chipley | |
| 14d. STREET ADDRESS 3725 Sears Road | | 14e. APT. NO. ____ | |
| 14f. ZIP CODE 32428 | | 14g. INSIDE CITY LIMITS? ____ Yes <input checked="" type="checkbox"/> NO | |
| 15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired" Linemanager | | 15b. KIND OF BUSINESS/INDUSTRY Chelco Electric | |
| 16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.) <input checked="" type="checkbox"/> White _____ Black or African American _____ American Indian or Alaskan Native (Specify tribe) _____ ____ Asian Indian _____ Chinese _____ Filipino _____ Japanese _____ Korean _____ Vietnamese _____ Other Asian (Specify) _____ ____ Native Hawaiian _____ Guamanian or Chamorro _____ Samoan _____ Other Pacific Isl. (Specify) _____ Other (Specify) _____ | | | |
| 17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was Hispanic or Haitian Origin.) ____ Yes (If Yes, Specify) <input checked="" type="checkbox"/> No _____ Mexican _____ Puerto Rican _____ Cuban _____ Central/South American _____ ____ Other Hispanic (Specify) _____ | | | |
| 18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.) ____ 8th or less _____ High school but no diploma <input checked="" type="checkbox"/> High school diploma or GED _____ College but no degree _____ College degree (specify): _____ Associates _____ Bachelor's _____ Master's _____ Doctorate _____ | | | |
| 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? ____ Yes <input checked="" type="checkbox"/> NO | | | |
| 20. FATHER'S NAME (First, Middle, Last, Suffix) Hubert F. Adams | | 20. MOTHER'S NAME (First, Middle, Maiden, Surname) Mildred Irene King | |
| 21a. INFORMANT'S NAME Vickie D. Weeks | | 21b. RELATIONSHIP TO DECEDENT Sister | |
| 22a. CITY OR TOWN DES | | 22b. STREET ADDRESS 6388 G Hwy 228 | |
| 22c. ZIP CODE 32435 | | 22d. ZIP CODE 32435 | |
| 24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Alaqua Cem. | | 25a. LOCATION - STATE FL | |
| 25b. LOCATION - CITY OR TOWN DeFuniak Spgs FL | | 26a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial _____ Entombment _____ Cremation _____ Donation _____ Removal from State _____ Other (Specify) _____ | |
| 26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? ____ Yes ____ NO | | 27a. LICENSE NUMBER (of Licensee) ____ | |
| 27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ____ | | 28. NAME OF FUNERAL FACILITY ____ | |
| 29a. FACILITY MAILING - STATE ____ | | 29b. CITY OR TOWN ____ | |
| 29c. STREET ADDRESS ____ | | 29d. ZIP CODE ____ | |
| DR. NAME Dr. LEWANDOWSKI | | DR. PHONE # 850-747-9969 | |
| TOD: 2:42 PM | | NEXT OF KIN SS # 892-5289 | |
| NEXT OF KIN PHONE # 892-5289 | | NEXT OF KIN SS # 892-5289 | |

Beth 263-88-2039
DOB 1-14-50
Cell 530-6592

UG

SERVICE DETAILS

PLACE: Chapel
 DATE: March 2008 TIME: 2:00 PM Thursday
 CLERGY: Rev. Phil McMillan

MUSIC: X

FAMILY WILL SIT IN: ☐ Chapel ☐ Family Room No. of Seats Reserved:

VISITATION HOURS: Friday 5 PM ROSARY

OPENED OR CLOSED CASKET: Open 6-8 PM Wed FH

PALLBEARERS:

HONORARY PALLBEARERS:

1
2
3
4
5
6

1) Family 1:30 PM @ Chapel
 2) Room 1:00 Lobby
 3) Casket Open or closed?

* IN LIEU OF FLOWERS: OK

FINAL DISPOSITION

☒ BURIAL ☐ ENTOMBMENT ☐ CREMATION Date:

CEMETERY/CREMATORY: Alameda Cem.
 City: County: Orangemark

Grave No.: Lot: Section: State:

Lot Owner:

If Cremation, Disposition of Ashes:

MISCELLANEOUS

COMPLEXION: Very Fair, Fair, Light Tan, Medium Tan,

CASKET:

Heavy Tan, Sallow, Olive, Dark, Other:

OUTER ENCLOSURE:

COLOR: Very Little, Light, Medium, Ruddy, Other:

CLOTHING:

USED COSMETICS: No, Light, Average

REMOVAL BY:

Hair dress

AUTOPSY: ☐ Yes ☐ No

Nail Polish

Glasses

EMBALMING BY:

Clary-Glenn Funeral Home
230 Park Avenue
DeFuniak Springs, Florida 32435
850-892-2511 FAX 850-892-5448

Obituary for David Franklin "Butch" Adams

Mr. David Adams, age 61, of Chipley, passed away Sunday, March 16 at his home. Mr. Adams was a native of DeFuniak Springs and graduated from Walton High School in 1965 where he was an all conference football player. He was an employee of the old Standard Oil Company of DeFuniak Springs and later worked and retired from Chelco. He was an avid fisherman and hunter and love to raise farm animals and work in his garden. He was Baptist by faith.

Mr. Adams is preceded in death by his father Hubert Adams, his wife Barbara Adams, one brother Tommy Adams, one sister Shirley Snipes and stepfather Vernon Bell. Survivors included his mother Ilene Bell of DeFuniak Springs, sisters Ann Adams of DeFuniak Springs, Vickie Weeks and husband David of DeFuniak Springs, Betty Stiffler of Gainesville, FL, Barbara Rowland and husband Gene of Gainesville, FL, numerous, nephews, nieces and many friends throughout the community.

Visitation services will be conducted at 6:00~8:00 PM, Wednesday, March 19, 2008 at Clary-Glenn Funeral Home Chapel; 230 Park Avenue, DeFuniak Springs, Florida 32435.

Funeral services will be conducted at 2:00 PM, Thursday, March 20, 2008 at Clary-Glenn Funeral Home Chapel, with Reverend Phil McMillian officiating.

Burial will follow in the Alaqua Cemetery.

You may go online to view obituaries, offer condolences and sign guest book, at www.clary-glenn.com

Clary-Glenn Funeral Home is in charge of arrangements.

Betty J. Stiffler

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|---|---|--|
| LOCAL FILE NO. | | 1. DECEDENT'S NAME (First, Middle, Last, Suffix) | | 2. SEX | |
| | | David Franklin Adams | | Male | |
| 3. DATE OF BIRTH (Month, Day, Year) | | 4a. AGE-Last Birthday (Years) | | 5. DATE OF DEATH (Month, Day, Year) | |
| January 17, 1947 | | 61 | | March 16, 2008 | |
| 6. SOCIAL SECURITY NUMBER | | 7. BIRTHPLACE (City and State or Foreign Country) | | 8. COUNTY OF DEATH | |
| 263-80-5710 | | DeFuniak Springs, Florida | | Washington | |
| 9. PLACE OF DEATH (Check only one) | | 10. FACILITY NAME (If not institution, give street address) | | 11a. CITY, TOWN, OR LOCATION OF DEATH | |
| HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input checked="" type="checkbox"/> Dead on Arrival NON-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) | | 3725 Sears Road | | Chipley | |
| 12. MARITAL STATUS (Specify) | | 13. SURVIVING SPOUSE'S NAME (If wife, give maiden name) | | 11b. INSIDE CITY LIMITS? | |
| <input type="checkbox"/> Married <input type="checkbox"/> Married, but Separated <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married | | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 14a. RESIDENCE - STATE | | 14b. COUNTY | | 14c. CITY, TOWN, OR LOCATION | |
| Florida | | Washington | | Chipley | |
| 14d. STREET ADDRESS | | 14e. APT. NO. | | 14f. ZIP CODE | |
| 3725 Sears Road | | | | 32428 | |
| 15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired" | | 15b. KIND OF BUSINESS/INDUSTRY | | 14g. INSIDE CITY LIMITS? | |
| Lineman | | Chelco Electric | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 16. DECEDENT'S RACE (Specify the race/faces to indicate what decedent considered himself/herself to be. More than one race may be specified.) | | | | | |
| <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Specify 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 Isl. (Specify) <input type="checkbox"/> Other (Specify) | | | | | |
| 17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) <input type="checkbox"/> Yes (If Yes, specify) <input checked="" type="checkbox"/> No <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central/South American <input type="checkbox"/> Other Hispanic (Specify) <input type="checkbox"/> Haitian | | | | | |
| 18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death) | | | | | |
| <input type="checkbox"/> 8th or less <input type="checkbox"/> High school but no diploma <input checked="" type="checkbox"/> High school diploma or GED <input type="checkbox"/> College degree (Specify): <input type="checkbox"/> Associate <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 20. FATHER'S NAME (First, Middle, Last, Suffix) | | | 21. MOTHER'S NAME (First, Middle, Maiden Surname) | | |
| Hubert F. Adams | | | Mildred Ilene King | | |
| 22a. INFORMANT'S NAME | | | 22b. RELATIONSHIP TO DECEDENT | | 23a. INFORMANT'S MAILING - STATE |
| Vickie D. Weeks | | | Sister | | Florida |
| 23b. CITY OR TOWN | | | 23c. STREET ADDRESS | | 23d. ZIP CODE |
| DeFuniak Springs | | | 6388 County Highway 228 | | 32435 |
| 24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | | | 25a. LOCATION - STATE | | 25b. LOCATION - CITY OR TOWN |
| Alaqua Cemetery | | | Florida | | DeFuniak Springs |
| 26a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) | | | | | |
| 26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 27a. LICENSE NUMBER (of Licensee) | | | 27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH | | |
| FO 47216 | | | | | |
| 28. NAME OF FUNERAL FACILITY | | | 29a. FACILITY'S MAILING - STATE | | |
| Clary-Glenn Funeral Home | | | Florida | | |
| 29b. CITY OR TOWN | | | 29c. STREET ADDRESS | | 29d. ZIP CODE |
| DeFuniak Springs | | | 230 Park Avenue | | 32435 |
| 30. CERTIFIER: <input checked="" type="checkbox"/> 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. (Check one) <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated. | | | | | |
| 31a. (Signature and Title of Certifier) | | | 31b. DATE SIGNED (mm/dd/yyyy) | | 32. TIME OF DEATH (24 hr) |
| | | | 3/18/08 | | 1442 |
| 34a. LICENSE NUMBER (of Certifier) | | | 34b. CERTIFIER'S NAME | | |
| ME 70992 | | | Dr. Kris Lewandowski | | |
| 35. NAME OF ATTENDING PHYSICIAN (If other than Certifier) | | | 36a. CERTIFIER'S - STATE | | |
| | | | Florida | | |
| 36b. CITY OR TOWN | | | 36c. STREET ADDRESS | | 36d. ZIP CODE |
| Panama City | | | 2101 Northside Drive, Unit 601 | | 32405 |
| 37. SUBREGISTRAR - Signature and Date | | | 38a. LOCAL REGISTRAR - Signature | | 38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.) |
| | | | Cheryl Reese | | March 18, 2008 |
| 39. PROBABLE MANNER OF DEATH: The following are under the jurisdiction of the medical examiner: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined | | | | | |
| 40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 41. CAUSE OF DEATH - PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) | | | | | |
| Acute Myocardial Infarction | | | | | |
| 42a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 43a. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY | | | | | |
| 43b. DATE OF SURGERY (Mo., Day, Yr.) | | | | | |
| 44. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 45. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| If Yes, specify timeframe: <input type="checkbox"/> at time of death <input type="checkbox"/> within 1 to 42 days of death <input type="checkbox"/> within 43 days to 1 year of death | | | | | |
| 46. DATE OF INJURY (Month, Day, Year) | | | | | |
| 47. TIME OF INJURY (24 hr.) | | | | | |
| 48. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 49a. LOCATION OF INJURY - STATE | | | | | |

| | | | | |
|---|--|---|------------------------|--|
| 14d. STREET ADDRESS 3725 Sears Road | | 14e. APT. NO. | 14f. ZIP CODE 32428 | 14g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired" Lineman | | 15b. KIND OF BUSINESS/INDUSTRY Chelco Electric | | |
| 16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Specify 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 Isl. (Specify) <input type="checkbox"/> Other (Specify) | | | | |
| 17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? <input type="checkbox"/> Yes (If Yes, specify) <input checked="" type="checkbox"/> No <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central/South American (Specify if decedent was of Hispanic or Haitian Origin.) <input type="checkbox"/> Other Hispanic (Specify) <input type="checkbox"/> Haitian | | | | |
| 18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.) <input type="checkbox"/> 8th or less <input type="checkbox"/> High school but no diploma <input checked="" type="checkbox"/> High school diploma or GED <input type="checkbox"/> College but no degree <input type="checkbox"/> College degree (Specify): <input type="checkbox"/> Associate <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate | | | | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 20. FATHER'S NAME (First, Middle, Last, Suffix) Hubert F. Adams | | 21. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Ilene King | | |
| 22a. INFORMANT'S NAME Vickie D. Weeks | | 22b. RELATIONSHIP TO DECEDENT Sister | | 23a. INFORMANT'S MAILING - STATE Florida |
| 23b. CITY OR TOWN DeFuniak Springs | | 23c. STREET ADDRESS 6388 County Highway 228 | | 23d. ZIP CODE 32435 |
| 24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Alaqua Cemetery | | 25a. LOCATION - STATE Florida | | 25b. LOCATION - CITY OR TOWN DeFuniak Springs |
| 26a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) | | | | |
| 26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 27a. LICENSE NUMBER (of Licensee) FO 47216 | | 27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i> |
| 28. NAME OF FUNERAL FACILITY Clary-Glenn Funeral Home | | | | 29a. FACILITY'S MAILING - STATE Florida |
| 29b. CITY OR TOWN DeFuniak Springs | | 29c. STREET ADDRESS 230 Park Avenue | | 29d. ZIP CODE 32435 |
| 30. CERTIFIER: <input checked="" type="checkbox"/> 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. (Check one) <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated. | | | | |
| 31a. (Signature and Title of Certifier) <i>[Signature]</i> | | 31b. DATE SIGNED (mm/dd/yyyy) 3/18/08 | | 32. TIME OF DEATH (24 hr.) 1442 |
| 34a. LICENSE NUMBER (of Certifier) ME 70996 | | 34b. CERTIFIER'S NAME Dr. Kris Lewandowski | | 35. NAME OF ATTENDING PHYSICIAN (If other than Certifier) |
| 36a. CERTIFIER'S - STATE Florida | | 36b. CITY OR TOWN Panama City | | 36c. STREET ADDRESS 2101 Northside Drive, Unit 601 |
| 36d. ZIP CODE 32405 | | | | |
| 37. SUBREGISTRAR - Signature and Date <i>[Signature]</i> | | 38a. LOCAL REGISTRAR - Signature <i>[Signature]</i> | | 38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.) March 18, 2008 |
| 39. PROBABLE MANNER OF DEATH: The following are under the jurisdiction of the medical examiner: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined | | | | |
| 40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 41. CAUSE OF DEATH - PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <u>ACUTE MYOCARDIAL INFARCTION</u> b. c. 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 | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I. | | | | |
| 42a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 43a. IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY | | 43b. DATE OF SURGERY (Mo., Day, Yr.) | | |
| 44. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 45. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify timeframe: <input type="checkbox"/> at time of death <input type="checkbox"/> within 1 to 42 days of death <input type="checkbox"/> within 43 days to 1 year of death | | | | |
| 46. DATE OF INJURY (Month, Day, Year) | | 47. TIME OF INJURY (24 hr.) | | 48. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 49a. LOCATION OF INJURY - STATE | | | | |
| 49b. CITY OR TOWN | | 49c. STREET ADDRESS | | 49d. APT. NO. |
| 49e. ZIP CODE | | | | |
| 50. DESCRIBE HOW INJURY OCCURRED | | | | |
| 51. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) | | | | |
| IF TRANSPORTATION INJURY, 52a. Status of Decedent <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) | | | | |
| 52b. Type of Vehicle <input type="checkbox"/> Car/Minivan <input type="checkbox"/> S.U.V. <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pickup Truck/Cargo Van <input type="checkbox"/> Bus <input type="checkbox"/> Heavy Transport <input type="checkbox"/> Other (Specify) | | | | |

WARNING:

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

DH FORM 1947 (08/04)

33753693

CERTIFICATION OF VITAL RECORD



* 3 3 7 5 3 6 9 3 *