

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

7955 (Advised) Form
New Print Release 7-11
306.2

93018742

CERTIFICATE OF DEATH
FLORIDA

1. DECEASED'S NAME (First, Middle, Last) EDWARD		2. SEX Male	
3. DATE OF DEATH (Month, Day, Year) February 22, 1990		4. SOCIAL SECURITY NUMBER 316-14 7613	
5. DATE OF BIRTH (Month, Day, Year) May 23, 1925		6. BIRTHPLACE (City and State or Foreign Country) Hammond Indiana	
7a. PLACE OF DEATH (Check only one - see instructions on other side)		7b. INSIDE CITY LIMITS? (Yes or No) No	
8. FACILITY NAME (If not institution, give street and number) 2424 39th Court		9. CITY, TOWN, OR LOCATION OF DEATH New Port Richey	
10. DECEASED'S USUAL OCCUPATION Police		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married	
12. DECEASED'S USUAL OCCUPATION Police Dept.		13. SURVIVING SPOUSE (If not, give maiden name) Dolores Yeager	
14. RESIDENCE - STATE Florida		15. COUNTY Pasco	
16. CITY, TOWN, OR LOCATION New Port Richey		17. STREET AND NUMBER 2424 39th Court	
18. INSIDE CITY LIMITS? (Yes or No) No		19. ZIP CODE 34655	
20. WAS DECEASED BORN OR HAD AN ORIGINAL RESIDENCE IN FLORIDA? No		21. RACE - Ethnic or Indian, Black, White, Other (Specify) White	
22. DECEASED'S EDUCATION (Specify only highest grade completed) College (1-12)		23. FATHER'S NAME (First, Middle, Last) Edward	
24. MOTHER'S NAME (First, Middle, Last) S. Glegg		25. MAJING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2424 39th Court, New Port Richey, Florida 34655	
26. INFORMANT'S NAME (Type/Print) Dolores Glegg		27. METHOD OF DISPOSITION (Check one) <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
28. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) South Lake County Crematory		29. LOCATION - City or Town, State Clearwater Florida	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>		31. LICENSE NUMBER (If Licensee) KA37	
32. NAME AND ADDRESS OF FACILITY National Cremation Society, 1217 SR 595, Holiday, Florida 34690		33. DATE SIGNED (Mo, Day, Yr) 2-23-90	
34. HOUR OF DEATH 8:23		35. DATE SIGNED (Mo, Day, Yr) 2-23-90	
36. HOUR OF DEATH 8:23		37. DATE SIGNED (Mo, Day, Yr) 2-23-90	
38. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) Philip Smith MD		39. ADDRESS OF PHYSICIAN (Type or Print) 1801 1/2 South Boulevard New Port Richey Florida	
40. SUBREGISTRAR SIGNATURE AND DATE <i>[Signature]</i>		41. LOCAL REGISTRAR SIGNATURE <i>[Signature]</i>	
42. DATE REGISTERED Feb 26 1990		43. PART I: Enter the diseases, injuries, or complications that caused the death. Do not state the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
44. IMMEDIATE CAUSE (Final disease or condition resulting in death) Respiratory Arrest		45. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
46. SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE (Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST.) Pulmonary Metastases		47. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
48. UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST. Squamous Cell Carcinoma of Piriform Sinus		49. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months	
50. PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Chronic Obstructive Pulmonary Disease		51. CASE REPORTED TO MEDICAL EXAMINER? No	
52. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? YES NO		53. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)	
54. IF SURGERY IS MENTIONED IN PART I OR ENTER CONDITION FOR WHICH IT WAS PERFORMED		55. DATE OF SURGERY (Mo, Day, Yr)	
56. PROBABLE MANNER OF DEATH (Specify) Accident, suicide or homicide, or undetermined		57. DATE OF SURGERY (Mo, Day, Yr)	
58. DATE OF INJURY (Month, Day, Year)		59. TIME OF INJURY	
60. INJURY AT WORK? (Yes or No)		61. DESCRIBE HOW INJURY OCCURRED	
62. PLACE OF INJURY - At home, farm, street, factory, etc (Specify)		63. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

RECORDED

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STATE OF INDIANA, S.S. #0. LAKE COUNTY, INDIANA. FILED FOR RECORD.

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FILED

MAR 24 1993

Oliver H. Boorde
STATE REGISTRAR

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

BY: *Barbara A. Shea*
DEPUTY REGISTRAR

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CERTIFICATION OF VITAL RECORD



HRS Form 512, Jan 89 (Obsolesces Previous Editions)

HRS Form 1564 (8/88)