Clarksville-Montgomery County Health Department

93039947 STATE DEPARTMENT OF PUBLIC HEALTH COOPERATING

PHONE: 648-5747

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

DECEDENT

1 DECEDENT'S NAME (First, Middle, Last): Mary Anne Holland
2 SEX: Female
3 DATE OF DEATH (Month, Day, Year): April 9, 1992
STATE FILE NUMBER:
4 SOCIAL SECURITY NUMBER (of Decedent): 309-30-9081
5a AGE - LAST BIRTHDAY (Years): 60
5b UNDER 1 YEAR: months / days
5c UNDER 24 HOURS: hours / minutes
6 DATE OF BIRTH (Month, Day, Year): 9-21-1931
7 BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] Yes 2 [X] No
9a PLACE OF DEATH (Check only one): HOSPITAL 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number): Clarksville Memorial Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Clarksville
9d COUNTY OF DEATH: Montgomery
10 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): William C. Holland
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Clerk
12b KIND OF BUSINESS/INDUSTRY: Drug Store
13a RESIDENCE - STATE: Florida
13b COUNTY: Dixie
13c CITY, TOWN OR LOCATION: Old Town
13d STREET AND NUMBER OR RURAL LOCATION: Rt. 2, Box 687
CENSUS TRACT
13e INSIDE CITY LIMITS? 1 [ ] Yes 2 [X] No
13f ZIP CODE: 32680
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify if yes) 1 [ ] Yes 2 [X] No
15 RACE - American Indian, Black, White, etc. (Specify): White
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

17 FATHER'S NAME (First, Middle, Last): Benjamie Dorton
18 MOTHER'S NAME (First, Middle, Maiden Surname): Edith Mongold

INFORMANT

19a INFORMANT'S NAME (Type/Print): William C. Holland
19b RELATIONSHIP TO DECEASED: Husband
19c MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 687 Old Town, Florida 32680

DISPOSITION

20a METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Chapel Hill Gardens
20c LOCATION - City or Town, State: Dade City, Florida
21a SIGNATURE OF FUNERAL DIRECTOR: ▶ Robert E. Sykes
21b LICENSE NUMBER OF FUNERAL DIRECTOR: 2043
21c SIGNATURE OF EMBALMER: ▶ Kenneth A. Bond
21d LICENSE NUMBER OF EMBALMER: 3738
22a NAME AND ADDRESS OF FUNERAL HOME: Sykes Funeral Home Inc. 424 Franklin St. Clarksville, TN 37040
22b LICENSE NUMBER OF FUNERAL HOME: 58

REGISTRAR

23. REGISTRAR'S SIGNATURE: ▶ Kay G Sheeton
24. DATE FILED (Month, Day, Year): April 10, 1992

CERTIFIER

25a PHYSICIAN - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
1 [ ] SIGNATURE AND TITLE OF PHYSICIAN: ▶ Steven M Culbertson MD
25b LICENSE NUMBER: MD010268
25c DATE SIGNED (Month, Day, Year): 4-10-92
26a MEDICAL EXAMINER - On the basis of examination and/or investigation, in my opinion, death occurred at the time, and place, and due to the cause(s) and manner as stated.
2 [ ] SIGNATURE AND TITLE OF MEDICAL EXAMINER: ▶
26b LICENSE NUMBER:
26c DATE SIGNED (Month, Day, Year):
27. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR MEDICAL EXAMINER) (Type/Print):

PHYSICIAN OR MEDICAL EXAMINER EXECUTING CERTIFICATE MUST COMPLETE AND SIGN MEDICAL CERTIFICATION WITHIN 48 HOURS.

CAUSE OF DEATH

28. PART I. Enter the diseases, injuries, or complications that 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. Cardio - respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Cardio - respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF): c. Unknown
DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death: a. Unk. b. 4 days c.

SEE INSTRUCTIONS ON OTHER SIDE

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.

29a WAS AN AUTOPSY PERFORMED? 1 [ ] Yes 2 [X] No
29b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] Yes 2 [ ] No

30. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be Determined
31a. DATE OF INJURY (Month, Day, Year):
31b TIME OF INJURY:
31c. INJURY AT WORK? 1 [ ] Yes 2 [ ] No
31d. DESCRIBE HOW INJURY OCCURRED:
31e PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify):
31f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

FILED

MAY 28 1993

Anna N. Antoine
AUDITOR LAKE COUNTY

STATE OF FLORIDA'S S.S. LAKE COUNTY I HEREBY CERTIFY THAT THE FOREGOING IS A TRUE COPY OF THE ORIGINAL RECORD FILED IN MY OFFICE JUN 8 49 AM 1993

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE RECORD FILED WITH THE DIVISION OF VITAL RECORDS, TENNESSEE DEPARTMENT OF HEALTH BY THE LOCAL HEALTH DEPARTMENT. THIS IS VALID ONLY WHEN THE EMBOSSED SEAL OF THE ISSUING HEALTH DEPARTMENT IS AFFIXED.

Kay G Sheeton
DEPUTY REGISTER

1206 MO