

# STATE OF MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH  
VITAL RECORDS

2000 FEB 29 AM 10:41

2000 013653  
MAR 02 1998

CERTIFICATE OF DEATH  
STATE FILE NUMBER 123-

1. NAME First: <u>ANNA</u> Middle: <u>Bell</u> Last: <u>COTTEN</u>		2. SEX <u>Female</u>		3a. HOUR OF DEATH <u>02:32A</u>		3b. DATE OF DEATH (Month, Day, Year) <u>02-08-1998</u>	
4. RACE (Specify White, Black, American Indian, etc.) <u>BLACK</u>		5a. AGE AT LAST BIRTHDAY <u>74</u> Years		5b. MOS		5c. DAYS	
5d. HOURS		5e. MINS		6. DATE OF BIRTH (Month, Day, Year) <u>5-1-1923</u>		7a. COUNTY OF DEATH <u>Hinds</u>	
7b. CITY OR TOWN OF DEATH <u>JACKSON</u>		7c. HOSPITAL OR OTHER INSTITUTION-NAME AND NUMBER (If not in city, give street address, route number, or other location) <u>University Medical Center 25</u>				7d. IF IN HOSP. OR INST SPECIFY INPT., OUTPT., EMER. RM. OR DOA <u>INPT</u>	
8. STATE OF BIRTH <u>MS</u>		9. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>12th</u>		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		11. SURVIVING SPOUSE (If wife, give maiden name) <u>Calvin Cotton</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) <u>no</u>		13. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.) <u>Afro-American</u>		14. SOCIAL SECURITY NUMBER <u>425-46-0160</u>		15a. USUAL OCCUPATION (Kind of work done most of working life) <u>domestic</u>	
15b. KIND OF BUSINESS OR INDUSTRY <u>house wife</u>		16a. RESIDENCE—STATE <u>MS</u>		16b. COUNTY <u>Copiah</u>		16c. CITY OR TOWN <u>HAZLEHURST</u>	
16d. INSIDE CITY LIMITS (Specify Yes or No) <u>yes</u>		16e. STREET AND NUMBER OR RURAL LOCATION <u>16132 Hwy 51 N</u>		17. FATHER—NAME First: <u>L D</u> Middle: Last: <u>Webb</u>		18. MOTHER—NAME First: <u>Floy</u> Middle: <u>DODDS</u>	
19a. INFORMANT—NAME (Type or print) <u>Marion Cotton Jones</u>				19b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) <u>P.O. Box 652 Hazlehurst, Mississippi 39083</u>			
20a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		20b. CEMETERY, CREMATORY—NAME <u>Domascus Cemetery</u>		20c. LOCATION (City and State) <u>W. Hazlehurst</u>		21. EMBALMER—SIGNATURE AND NUMBER <u>Gregory D. ... 143175</u>	
21b. FUNERAL HOME—NAME AND MISSISSIPPI I.D. NUMBER <u>Hazlehurst Funeral Home H15</u>				21c. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) <u>P.O. Box 102, Hazlehurst, Mississippi 39083</u>			
22a. PERSON WHO PRONOUNCED DEATH—NAME AND TITLE (Type or print) <u>CRYSTAL SUMRALL, MD</u>				22b. PRONOUNCED DEAD (Month, Day, Year) <u>ON 02/08/98</u>		22c. PRONOUNCED DEAD (Hour) AT <u>02:32 AM</u>	
23a. CERTIFIER—NAME (Type or print) <u>KIMBERLY HARKINS MD</u>				23b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) <u>2500 North State St., Jackson, MS 39216</u>			
24a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated. SIGNATURE: <u>[Signature]</u> MD		24b. DATE SIGNED (Month, Day, Year) <u>02 08 98</u>		24c. STATE LICENSE NUMBER <u>15503</u>		24d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or print) <u>John Buxer MD</u>	
24e. On the basis of examination and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated. SIGNATURE: <u>[Signature]</u>		24f. TITLE <b>FILED</b>		24g. DATE SIGNED (Month, Day, Year) <u>FEB 29 2000</u>		24h. INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
25. PART I. DEATH CAUSED BY: (a) <u>myocardial infarction</u>		(b) <u>arteriosclerotic vascular disease</u>		(c) <u>end stage renal disease</u>		Interval between onset and death <u>years</u>	
26. PART II. OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not resulting in the underlying cause given in PART I.				27. AUTOPSY (Yes or No)		28. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)	
29a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)		29b. DATE OF INJURY (Month, Day, Year)		29c. HOUR OF INJURY		29d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED	
29e. INJURY AT WORK (Yes or No)		29f. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.)		29g. LOCATION		Street or route number City or town State	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE

F. E. Thompson Jr. MD  
F. E. Thompson, Jr., M.D., M.P.H.  
STATE HEALTH OFFICER

Nita Cox Gunter  
Nita Cox Gunter  
STATE REGISTRAR

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