STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

TYPE IN PERMANENT BLACK INK

LOCAL FILE NO.

2008 017813

DEMOGRAPHIC INFORMATION TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last, Suffix): Eleanor Brello
2. SEX: Female
3. DATE OF BIRTH (Month, Day, Year): January 11, 1914
4a. AGE - Last Birthday (Years): 94
4b. UNDER 1 YEAR Months / Days:
4c. UNDER 1 DAY Hours / Minutes:
5. DATE OF DEATH (Month, Day, Year): January 31, 2008
6. SOCIAL SECURITY NUMBER: 321-03-7214
7. BIRTHPLACE (City and State or Foreign Country): Shelby, Indiana
8. COUNTY OF DEATH: St. Johns
9. PLACE OF DEATH (Check only one): HOSPITAL: ___ Inpatient ___ Emergency Room/Outpatient ___ Dead on Arrival; NON-HOSPITAL: ___ Hospice facility X Nursing Home/Long Term Care Facility ___ Decedent's Home ___ Other (Specify)
10. FACILITY NAME (If not institution, give street address): Ponce de Leon Care Center
11a. CITY, TOWN, OR LOCATION OF DEATH: St. Augustine
11b. INSIDE CITY LIMITS? ___ Yes X No
12. MARITAL STATUS (Specify): ___ Married ___ Married, but Separated X Widowed ___ Divorced ___ Never Married
13. SURVIVING SPOUSE'S NAME (If wife, give maiden name):
14a. RESIDENCE - STATE: Florida
14b. COUNTY: St. Johns
14c. CITY, TOWN, OR LOCATION: St. Augustine
14d. STREET ADDRESS: 4972 Atlantic View
14e. APT. NO.:
14f. ZIP CODE: 32080
14g. INSIDE CITY LIMITS? ___ Yes X No
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. Do not use "Retired"): Beautician/Owned Beauty Shop
15b. KIND OF BUSINESS/INDUSTRY: Cosmetology
16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.): X 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 of Hispanic or Haitian Origin.) ___ Yes (If Yes, specify) X No ___ Mexican ___ Puerto Rican ___ Cuban ___ Central/South American ___ Other Hispanic (Specify) ___ Haitian
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 X High school diploma or GED ___ College but no degree College degree (Specify): ___ Associate ___ Bachelor's ___ Master's ___ Doctorate
19. WAS DECEDENT EVER IN U.S. ARMED FORCES? ___ Yes X No
20. FATHER'S NAME (First, Middle, Last, Suffix): Melville Jones
21. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Belle Ahlgrim
22a. INFORMANT'S NAME: Ken Jones
22b. RELATIONSHIP TO DECEDENT: Brother
23a. INFORMANT'S MAILING - STATE: Indiana
23b. CITY OR TOWN: Lowell
23c. STREET ADDRESS: 10506 West 181st Avenue
23d. ZIP CODE: 46356
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Craig Crematory Memorial Park
25a. LOCATION - STATE: Florida
25b. LOCATION - CITY OR TOWN: Saint Augustine
26a. METHOD OF DISPOSITION: ___ Burial ___ Entombment X Cremation ___ Donation ___ Removal from State ___ Other (Specify)
26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? X Yes ___ No
27a. LICENSE NUMBER (of Licensee): 44188
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
28. NAME OF FUNERAL FACILITY: Craig Funeral Home Crematory Memorial Park
29a. FACILITY'S MAILING - STATE: Florida
29b. CITY OR TOWN: St. Augustine
29c. STREET ADDRESS: 1475 Old Dixie Highway
29d. ZIP CODE: 32084

MEDICAL CERTIFIER

30. CERTIFIER: (Check one) X 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. ___ 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): TDK MD
31b. DATE SIGNED (mm/dd/yyyy): 02/05/2008
32. TIME OF DEATH (24 hr.): 1445
33. MEDICAL EXAMINER'S CASE NUMBER
34a. LICENSE NUMBER (Of Certifier): ME82769
34b. CERTIFIER'S NAME: Todd Batenhorst MD
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)
36a. CERTIFIER'S - STATE: FL
36b. CITY OR TOWN: St. Augustine
36c. STREET ADDRESS: 130 Health Park Blvd.
36d. ZIP CODE: 32086
37. SUBREGISTRAR - Signature and Date
38a. LOCAL REGISTRAR - Signature: Carol Medeiros CDR
38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.): FEB 08 2008

CAUSE OF DEATH TO BE COMPLETED BY: MEDICAL CERTIFIER (Obsoletes previous editions which may not be used)

39. PROBABLE MANNER OF DEATH: Natural; The following are under the jurisdiction of the medical examiner: ___ Accident ___ Suicide ___ Homicide ___ Pending Investigation ___ Undetermined
40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? ___ Yes ___ No
41. CAUSE OF DEATH - PART I. (See instructions on back) 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. Approximate Interval: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. FAILURE TO THRIVE
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. GREAT AGE
c.
d.

FILED
MAR 1 1 2008
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.: SSS, CAD, PVD
42a. WAS AN AUTOPSY PERFORMED? ___ Yes X No
42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ___ Yes
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? ___ Unknown
45. IF FEMALE, WAS SHE PREGNANT WITHIN THE PAST YEAR: ___ Yes ___ No ___ Unknown If Yes, specify timeframe: ___ at time of death ___ within 1 to 42 days of death ___ within 43 days to 1 year before death
46. DATE OF INJURY (Month, Day, Year)
47. TIME OF INJURY (24hr.)
48. INJURY AT WORK? ___ Yes ___ 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 ___ Driver/Operator ___ Passenger ___ Pedestrian ___ Other (Specify)
52b. Type of Vehicle ___ Car/Minivan ___ S.U.V. ___ Motorcycle ___ Pickup Truck/Cargo Van ___ Bus ___ Heavy Transport ___ Other (Specify)

3719

DH Form 512, Jul. 2004 (Obsoletes previous editions which may not be used)

FEB 08 2008

Carol Medeiros CDR

11 CS 20

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2008 MAR 11 PM 12:54 MICHAEL B. BROWN RECORDER

VOID IF ALTERED OR ERASED

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DH FORM 1947 (08/04)

FLORIDA DEPARTMENT OF HEALTH

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CERTIFICATION OF VITAL RECORD