STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

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LOCAL FILE NO.

FLORIDA CERTIFICATE OF DEATH

2009 028329

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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: [redacted]-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 ___ Haitian
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 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: [signature]
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: 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.
(Check one) ___ 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): [signature] 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	

State of Florida, Department of Health, Vital Statistics

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LAKE COUNTY
FILED FOR RECORD
2009 MAY -1 AM 9:36
MICHAEL A. BROWN
RECORDER

FILED
APR 30 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Carol Medeiros CDR

FEB 26 2009
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CHICAGO TITLE INSURANCE COMPANY

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FLORIDA DEPARTMENT OF HEALTH

DH FORM 1947 (08/04)

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CERTIFICATION OF VITAL RECORD