STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

TYPE IN PERMANENT BLACK INK

FLORIDA CERTIFICATE OF DEATH

LOCAL FILE NO.

DECEDENT'S DEMOGRAPHIC INFORMATION TO BE COMPLETED BY: FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last, Suffix): Adell Louise Watson Gray
2. SEX: Female
3. DATE OF BIRTH (Month, Day, Year): May 20, 1932
4a. AGE-Last Birthday (Years): 75
4b. UNDER 1 YEAR: Months ___ Days ___
4c. UNDER 1 DAY: Hours ___ Minutes ___
5. DATE OF DEATH (Month, Day, Year): June 13, 2007
6. SOCIAL SECURITY NUMBER: 267-56-4889
7. BIRTHPLACE (City and State, or Foreign Country): Columbia County, Florida
8. COUNTY OF DEATH: Alachua
9. PLACE OF DEATH (Check only one): HOSPITAL: X Inpatient ___ Emergency Room/Outpatient ___ Dead On Arrival; NON-HOSPITAL: ___ Hospice Facility ___ Nursing Home/Long Term Care Facility ___ Decedent's Home ___ Other (Specify)
10. FACILITY NAME (If not institution, give street address): Shands Hospital @ U. of F.
11a. CITY, TOWN, OR LOCATION OF DEATH: Gainesville
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): None
14a. RESIDENCE - STATE: Florida
14b. COUNTY: Duval
14c. CITY, TOWN, OR LOCATION: Jacksonville
14d. STREET AND NUMBER: 4226 Katanga Drive South
14e. APT. NO.:
14f. ZIP CODE: 32209
14g. INSIDE CITY LIMITS? X Yes ___ No
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired": Cosmotologist
15b. KIND OF BUSINESS/INDUSTRY: Hair / Skin Care
16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.)
___ White X 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/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 ___ High school diploma or GED ___ College but no degree ___ College degree (Specify): X 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): Simon C. Watson
21. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Anderson
22a. INFORMANT'S NAME: Siwina Gray
22b. RELATIONSHIP TO DECEDENT: Daughter
23c. INFORMANT'S MAILING - STATE: Florida
23b. CITY OR TOWN: Jacksonville
23c. STREET ADDRESS: 9031 7th Avenue
23d. ZIP CODE: 32208
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Mount Moriah Cemetery
25a. LOCATION - STATE: Florida
25b. LOCATION - CITY OR TOWN: Fort White
26a. METHOD OF DISPOSITION: X Burial ___ Entombment ___ Cremation ___ Donation ___ Removal From State ___ Other (Specify)
26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? ___ Yes ___ No
27a. LICENSE NUMBER (of Licensee): FE6191
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: ► [signature]
28. NAME OF FUNERAL FACILITY: Buggs-Bellamy Funeral Services, Inc.
29a. FACILITY'S MAILING - STATE: Florida
29b. CITY OR TOWN: Jacksonville
29c. STREET ADDRESS: 2936 Jerry Lane
29d. ZIP CODE: 32218

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): ► Eloise M Harman
31b. DATE SIGNED (mm/dd/yyyy): 6/20/07
32. TIME OF DEATH (24 hr.): 1855
33. MEDICAL EXAMINER'S CASE NUMBER:
34a. LICENSE NUMBER (of Certifier): 31524
34b. CERTIFIER'S NAME: Dr. Eloise M. Harman, M.D.
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier):
36a. CERTIFIER'S - STATE: Florida
36b. CITY OR TOWN: Gainesville
36c. STREET ADDRESS: 1600 SW Archer Road
36d. ZIP CODE: 32610
37. SUBREGISTRAR - Signature and Date: ► Mary H Bellamy 06/27/2007
38a. LOCAL REGISTRAR - Signature: ► Shirley Allen CDR
38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.): June 28 2007

CAUSE OF DEATH TO BE COMPLETED BY: MEDICAL CERTIFIER

39. PROBABLE MANNER OF DEATH: X 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 X 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.

	Cause	Approximate Interval: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	septic shock	days
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 — Due to (or as a consequence of): b.	cholangiocarcinoma	weeks
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.: prior gastric carcinoma, hypertension
42a. WAS AN AUTOPSY PERFORMED? ___ Yes X No
42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ___ Yes X No
43a. IF SURGERY MENTIONED IN PART I OR PART II, ENTER REASON FOR SURGERY:
43b. DATE OF SURGERY (Mo., Day, Yr.):
44. DID TOBACCO USE CONTRIBUTE TO DEATH? ___ Yes ✓ No ___ Probably ___ 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 of death
46. DATE OF INJURY (Month, Day, Year):
47. TIME OF INJURY (24 hr.):
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):

State of Florida, Department of Health, Vital Statistics

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

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

State of Florida, Department of Health, Vital Statistics

29b. CITY OR TOWN: Jacksonville | 29c. STREET ADDRESS: 2936 Jerry Lane | 29d. ZIP CODE: 32218

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)	31b. DATE SIGNED (mm/dd/yyyy)	32. TIME OF DEATH (24 hr.)	33. MEDICAL EXAMINER'S CASE NUMBER
► Eloise Harman	6/20/07	1855	

34a. LICENSE NUMBER (of Certifier)	34b. CERTIFIER'S NAME	35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)
31524	Dr. Eloise M. Harman, M.D.	

36a. CERTIFIER'S - STATE	36b. CITY OR TOWN	36c. STREET ADDRESS	36d. ZIP CODE
Florida	Gainesville	1600 SW Archer Road	32610

37. SUBREGISTRAR - Signature and Date	38a. LOCAL REGISTRAR, Signature	38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.)
► Mary H Bellamy 06/27/2007	► Shirley Allen CSR	June 28 2007

CAUSE OF DEATH TO BE COMPLETED BY: MEDICAL CERTIFIER

39. PROBABLE MANNER OF DEATH: [X] 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 [X] 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. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology

IMMEDIATE CAUSE (Final disease or condition resulting in death)

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**

		Approximate Interval: Onset to Death
a.	septic shock	days
	Due to (or as a consequence of)	
b.	Cholangiocarcinoma	weeks
	Due to (or as a consequence of)	
c.		
	Due to (or as a consequence of)	
d.		

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.: priorgastric carcinoma, hypertension

42a. WAS AN AUTOPSY PERFORMED? [ ] Yes [X] No

42b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? [ ] Yes [X] No

43a. IF SURGERY MENTIONED IN PART I OR PART II, ENTER REASON FOR SURGERY

43b. DATE OF SURGERY (Mo., Day, Yr.)

44. DID TOBACCO USE CONTRIBUTE TO DEATH? [ ] Yes [✓] No [ ] Probably [ ] 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 of death

46. DATE OF INJURY (Month, Day, Year)	47. TIME OF INJURY (24 hr.)	48. INJURY AT WORK?	49a. LOCATION OF INJURY - STATE
		[ ] Yes [ ] No	

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)

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

Shirley Allen CSR June 28 2007

WARNING: THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

FLORIDA DEPARTMENT OF HEALTH

DH FORM 1947 (08/04)

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CERTIFICATION OF VITAL RECORD

33921150