

# CERTIFIED COPY

I HEREBY CERTIFY THE COPY REPRODUCED BELOW TO BE A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD ON FILE IN THE BUREAU OF VITAL STATISTICS OF THE STATE OF FLORIDA, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, AT JACKSONVILLE, FLORIDA.

(NOT VALID UNLESS THE SEAL OF THE STATE OF FLORIDA, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, IS AFFIXED.)

*Everett H. Williams, Jr.*

OCT 13 1968

STATE REGISTRAR FOR VITAL STATISTICS  
DEPARTMENT OF HEALTH AND REHABILITATIVE  
SERVICES

STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

STATE FILE NO. 68-051094

FLORIDA

REGISTRAR'S NO. 68 2324

BIRTH NO.		REGISTRAR'S NO. <u>68 2324</u>	
1. PLACE OF DEATH a. COUNTY <u>Orange</u>		CODE NO. <u>58-084</u>	2. USUAL RESIDENCE (If there deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Orange</u>
b. CITY, TOWN, OR LOCATION <u>Orlando</u>		c. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	c. CITY, TOWN, OR LOCATION <u>Orlando</u> e. IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Orange Memorial Hospital</u>		d. STREET ADDRESS <u>902 Davison Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>ESMOND</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24, 1891</u>
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		14. MOTHER'S MAIDEN NAME <u>Minnie (Unavailable)</u>	
13. FATHER'S NAME <u>Douglas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Minnie (Unavailable)</u>	
6. SOCIAL SECURITY NO. <u>484-28-4452</u>	17. INFORMANT'S SIGNATURE <u>Mrs. Suzanne F. Jones, 902 Davison Avenue, Orlando, Florida</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ct of Urinary Bladder</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. (Probably) ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>8-26-68</u> to <u>9-25-68</u> and last saw <u>her</u> alive on <u>9-25-68</u> . Death occurred at <u>appt 4 Co Ave</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Print or type) <u>William K. Hill, MD 415 Brincliffe Dr</u>		22b. ADDRESS	
22c. DATE SIGNED <u>9-26-68</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/28/68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Apopka, Florida</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bryghed</u>		ADDRESS <u>Cox-Parker Funeral Home</u>	
25. DATE RECD. BY LOCAL REG. <u>SEP 25 1968</u>		26. REGISTRAR'S SIGNATURE <u>W. H. Ash, MD.</u>	

MEDICAL CERTIFICATION