

12-30-01

Mrs. Blanca, Director

ORIGINAL

RECEIVED FPSC
02 JAN -2 AM 10:46

COMMISSION
CLERK

As requested a copy of my
husbands death certificate
This is in regard to docket

number 011251-1X Tom's Phone.

Thank you.

Patricia F. Jones
4404 Rainer Road
Jacksonville, FL
32210

904-778-2185

- APP
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DOCUMENT NUMBER-DATE

00014 JAN-28

FPSC-COMMISSION CLERK

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO. _____

1 DECEDENT'S NAME FIRST MIDDLE LAST
Steven Michael Jones 2 SEX Male

3 DATE OF DEATH (Month, Day, Year)
December 22, 1998 4 SOCIAL SECURITY NUMBER [REDACTED] 5a AGE-Last Birthday (years) 48 5b UNDER 1 YEAR Months Days 5c UNDER 1 Day Hours Minutes

6 DATE OF BIRTH (Month, Day, Year)
October 12, 1950 7 BIRTHPLACE (City and State or Foreign Country)
Oakland, California 8 WAS DECEDENT EVER IN US ARMED FORCES? (Yes or No) Yes

9a. PLACE OF DEATH (Check only one; see instructions on other side)
HOSPITAL Inpatient ER/Outpatient DOA OTHER Nursing Home Residence Other (Specify) _____ 9b. INSIDE CITY LIMITS? (Yes or No) Yes

9c. FACILITY NAME (If not institution, give street and number)
Columbia-Memorial Hospital Jacksonville Jacksonville 9d. CITY, TOWN, OR LOCATION OF DEATH Jacksonville 9e. COUNTY OF DEATH Duval

10a. DECEDENT'S USUAL OCCUPATION Salesman 10b. KIND OF BUSINESS/INDUSTRY Sales 11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married 12 SURVIVING SPOUSE (If wife, give maiden name) Patricia Fair Worrell

13a. RESIDENCE - STATE Florida 13b. COUNTY Duval 13c. CITY, TOWN, OR LOCATION Jacksonville 13d. STREET AND NUMBER 4404 Rainer Road

13e. INSIDE CITY LIMITS? (Yes or No) Yes 13f. ZIP CODE 32210 14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) X No Yes Specify _____ 15 RACE - American Indian, Black, White, etc. Specify White 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary College (1 - 4 or 5 -) 10 - 12 12

17 FATHER'S NAME (First, Middle, Last) Charles E. Jones 18 MOTHER'S NAME (First, Middle, Maiden Surname) Joy Glover

19a. INFORMANT'S NAME (Type/Print) Patricia Fair Worrell Jones 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4404 Rainer Road Jacksonville, FL 32210

20a. METHOD OF DISPOSITION X Burial Cremation Removal from State Donation Other (Specify) _____ 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Jacksonville Memory Gardens 20c. LOCATION - City or Town, State Orange Park, Florida

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH [Signature] 21b. LICENSE NUMBER (of Licensee) 1749 21c. NAME AND ADDRESS OF FACILITY Jacksonville Memory Gardens Funeral Home 111 Blanding Blvd Orange Park, FL 32073

22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated. (Signature and Title) [Signature] 22b. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner as stated. (Signature and Title) [Signature]

22c. DATE SIGNED (Mo., Day, Yr.) 12/29/98 22d. HOUR OF DEATH 11:00 PM M 23b. DATE SIGNED (Mo., Day, Yr.) _____ 23c. HOUR OF DEATH _____ M

22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) _____ 23d. MEDICAL EXAMINER'S CASE # _____

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) Alejandro A. Radi, M.D. 3599 University Blvd. S. Ste. 48 Jax 32246

25a. SUBREGISTRAR - SIGNATURE AND DATE [Signature] 25b. LOCAL REGISTRAR - SIGNATURE Jean Sculliette Deputy 25c. DATE REGISTERED DEC 30 1998

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Massive UGI Bleeding (CONSEQUENCE OF) _____

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____ (CONSEQUENCE OF) _____

c. _____ (CONSEQUENCE OF) _____

d. _____ (CONSEQUENCE OF) _____

PART II. Other significant conditions contributing to the underlying cause given in Part I

PERFORMED? (Yes or No) No 27b. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No) No 28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or No) No

29. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? YES NO 30a. IF SURGERY IS MENTIONED IN PART I OR II ENTER CONDITION FOR WHICH IT WAS PERFORMED. 30b. DATE OF SURGERY (Mo., Day, Year)

31. PROBABLE MANNER OF DEATH (Specify) Natural, accident, suicide, homicide, or undetermined. 32a. DATE OF INJURY (Month, Day, Year) 32b. TIME OF INJURY M 32c. INJURY AT WORK? (Yes or No) 32d. DESCRIBE HOW INJURY OCCURRED

32e. PLACE OF INJURY - At home, farm, street, factory, etc. (Specify) Natural 32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

VOID IF ALTERED OR ERASED

DEC. 30, 1998

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

[Signature] Chief Deputy Registrar

State Registrar

WARNING:

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HRS FORM 1564A (9-96)

