

THIS DOCUMENT HAS A LIGHT BACKGROUND ON TRUE WATERMARKED PAPER. HOLD TO LIGHT TO VERIFY FLORIDA WATERMARK.

BUREAU of VITAL STATISTICS

CERTIFICATE OF DEATH
FLORIDA

8 9 0 6 6 4 3 2

LOCAL FILE NO.

1 DECEDENT'S NAME (First, Middle, Last) SUSAN H. ROLLASON				2 SEX FEMALE	
3 DATE OF DEATH (Month, Day, Year) JUNE 26, 1989		4 SOCIAL SECURITY NUMBER 020-26-0929		5a. AGE-Last Birthday (years) 99	
5b. UNDER 1 YEAR Months: _____ Days: _____		5c. UNDER 1 Day Hours: _____ Minutes: _____			
6 DATE OF BIRTH (Month, Day, Year) NOVEMBER 2, 1889		7 BIRTHPLACE (City and State or Foreign Country) BROOKLINE, MASSACHUSETTS		8 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) NO	
9a. PLACE OF DEATH (Check only one: see instructions on other side) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				9b. INSIDE CITY LIMITS? (Yes or No) YES	
9c. FACILITY NAME (If not institution, give street and number) SHORES ACRES NURSING HOME			9d. CITY, TOWN, OR LOCATION OF DEATH ST. PETERSBURG		9e. COUNTY OF DEATH PINELLAS
10a. DECEDENT'S USUAL OCCUPATION HOMEMAKER		10b. KIND OF BUSINESS/INDUSTRY OWN HOME		11. MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify) WIDOWED	
12. SURVIVING SPOUSE (If wife, give maiden name)					
13a. RESIDENCE — STATE FLORIDA		13b. COUNTY PINELLAS		13c. CITY, TOWN, OR LOCATION ST. PETERSBURG	
13d. STREET AND NUMBER 4540 OVERLOOK DRIVE N.E.					
13e. INSIDE CITY LIMITS? (Yes or No) YES		13f. ZIP CODE 33703		14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes — If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) No	
15. RACE — American Indian, Black, White, etc. Specify: WHITE		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) 4			
17. FATHER'S NAME (First, Middle, Last) GEORGE R. WALES			18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL HERVEY		
19a. INFORMANT'S NAME (Type/Print) ELIZABETH GREENE			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4540 OVERLOOK DRIVE N.E. ST. PETERSBURG, FLORIDA 33703		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) SOUTHEASTERN CREMATORY		20c. LOCATION — City or Town, State CLEARWATER, FLORIDA	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Augusta Steele</i>		21b. LICENSE NUMBER (of Licensee) 2895		21c. NAME AND ADDRESS OF FACILITY NATIONAL CREMATION SOCIETY 4945 EAST BAY DRIVE, CLEARWATER, FLORIDA 34624	
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) <i>Emiliana S. Garcia</i>		23a. 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) _____			
22b. DATE SIGNED (Mo., Day, Yr.) 6-29-89		22c. HOUR OF DEATH 2:20 P M		23b. DATE SIGNED (Mo., Day, Yr.) _____	
22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		23c. HOUR OF DEATH _____		23d. PRONOUNCED DEAD (Mo., Day, Yr.) _____	
23e. PRONOUNCED DEAD (Hour) _____					
24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) EMILIANA GARCIA MD 1201 5TH AVENUE NORTH ST. PETERSBURG, FLORIDA 33705					
25a. SUBREGISTRAR — SIGNATURE AND DATE <i>Helma E. Decker June 29, 1989</i>			25b. LOCAL REGISTRAR — SIGNATURE <i>Patricia A. DeBruijn</i>		25c. DATE REGISTERED June 29, 1989

VOID IF ALTERED OR ERASED

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C. Meade Grigg
State Registrar

Date Issued: **AUG 20 2013**

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DH FORM 1946 (03-13)

CERTIFICATION OF VITAL RECORD

