

OFFICE of VITAL STATISTICS

CERTIFIED COPY

FLORIDA CERTIFICATE OF DEATH

TYPE IN
PERMANENT
BLACK INK

LOCAL FILE NO.

1. DECEDENT'S NAME (First, Middle, Last, Suffix) Katie Frances Mangum		2. SEX Female	
3. DATE OF BIRTH (Month, Day, Year) April 22, 1935		4a. AGE-Last Birthday (Years) 71	
4b. UNDER 1 YEAR Months _____ Days _____		4c. UNDER 1 DAY Hours _____ Minutes _____	
5. DATE OF DEATH (Month, Day, Year) December 24, 2006			
6. SOCIAL SECURITY NUMBER		7. BIRTHPLACE (City and State or Foreign Country) Shawnee, Oklahoma	
8. COUNTY OF DEATH Gulf			
9. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival NON-HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
10. FACILITY NAME (If not institution, give street address) 2430 Hayes Avenue		11a. CITY, TOWN, OR LOCATION OF DEATH Port Saint Joe	
11b. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
12. MARITAL STATUS (Specify) <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married			
13. SURVIVING SPOUSE'S NAME (If wife, give maiden name) Thomas Andrew Mangum			
14a. RESIDENCE - STATE Florida		14b. COUNTY Gulf	
14c. CITY, TOWN, OR LOCATION Port Saint Joe			
14d. STREET ADDRESS 2430 Hayes Avenue		14e. APT. NO. 32456	
14f. ZIP CODE 32456		14g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired" Homemaker		15b. KIND OF BUSINESS/INDUSTRY Own Home	
16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Specify tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Isl. (Specify) <input type="checkbox"/> Other (Specify)			
17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.) <input checked="" type="checkbox"/> Yes (If Yes, specify) <input type="checkbox"/> No <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central/South American <input type="checkbox"/> Other Hispanic (Specify) <input type="checkbox"/> Haitian			
18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.) <input type="checkbox"/> 8th or less <input checked="" type="checkbox"/> High school but no diploma <input type="checkbox"/> High school diploma or GED <input type="checkbox"/> College but no degree <input type="checkbox"/> College degree (Specify): <input type="checkbox"/> Associate <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate			19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
20. FATHER'S NAME (First, Middle, Last, Suffix) Percy Othan Burrows		21. MOTHER'S NAME (First, Middle, Maiden Surname) Oma Jenkins	
22a. INFORMANT'S NAME Thomas A. Mangum		22b. RELATIONSHIP TO DECEDENT Spouse	
23a. INFORMANT'S MAILING - STATE Florida			
23b. CITY OR TOWN Port Saint Joe		23c. STREET ADDRESS 2430 Hayes Avenue	
23d. ZIP CODE 32456-			
24. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Holly Hill Cemetery		25a. LOCATION - STATE Florida	
25b. LOCATION - CITY OR TOWN Port Saint Joe			
26a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)			
26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? <input type="checkbox"/> Yes <input type="checkbox"/> No		27a. LICENSE NUMBER (of Licensee) FE1994	
27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>			
28. NAME OF FUNERAL FACILITY Comforter Funeral Home		29a. FACILITY'S MAILING - STATE Florida	
29b. CITY OR TOWN Port Saint Joe		29c. STREET ADDRESS 601 Long Avenue	
29d. ZIP CODE 32456			
30. CERTIFIER: <input checked="" type="checkbox"/> 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) <input type="checkbox"/> 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) <i>[Signature]</i>		31b. DATE SIGNED (mm/dd/yyyy) 12/27/2006	
31c. TIME OF DEATH (24 hr.) 1520		33. MEDICAL EXAMINER'S CASE NUMBER	
34a. LICENSE NUMBER (of Certifier) ME85024		34b. CERTIFIER'S NAME Dr. Keith B. Banton	
35. NAME OF ATTENDING PHYSICIAN (If other than Certifier)			
36a. CERTIFIER'S - STATE Florida		36b. CITY OR TOWN Panama City	
36c. STREET ADDRESS 3230 East. 15th Street, Suite B		36d. ZIP CODE 32405	
37. SUBREGISTRAR - Signature and Date <i>[Signature]</i>		38a. LOCAL REGISTRAR - Signature <i>[Signature]</i>	
		38b. DATE FILED BY REGISTRAR (Mo., Day, Yr.) January 2, 2007	
39. PROBABLE MANNER OF DEATH: The following are under the jurisdiction of the medical examiner:			
40. REPORTED TO MEDICAL EXAMINER DUE TO			

State of Florida, Department of Health, Vital Statistics

MEDICAL CERTIFIER

VOID IF ALTERED OR ERASED