CERTIFICATE OF DEATH/STATE OF GEORGIA

Birth Number | Local File Number | State File Number

TYPE OR PRINT IN PERMANENT BLACK OR BLUE-BLACK INK

DECEASED

1a. DECEDENT'S NAME (First, Middle, Last): LOUVIE MAE JONES
1b. IF DECEDENT IS FEMALE, ENTER MAIDEN LAST NAME: SINYARD
2. SEX: Female
3. DATE OF DEATH (Mo., Day, Year): November 5, 1995
4. RACE (White, Black, Amer. Indian, etc.) (Specify): White
5. ORIGIN OF DECEDENT (Italian, Mex., French, English, etc.)
6. DATE OF BIRTH (Mo., Day, Year): Apr 3, 1907
7a. AGE-Last Birthday (Years): 88
7b. UNDER 1 YEAR: Mos. Days
7c. UNDER 1 DAY: Hours Mins.
8a. COUNTY OF DEATH: Cobb
8b. CITY, TOWN or LOCATION OF DEATH: Austell
9a. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and No.): Promina Cobb Medical Center
9b. IF HOSPITAL OR INST. (Indicate DOA, OP/EMER, Inp., Inpatient) (Specify): OP/EMER
10a. STATE AND COUNTY OF BIRTH (If not in USA, name Country): Ga. /Paulding
10b. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
12. SPOUSE (If married or widowed, give spouse's name-if wife, give maiden name): Herschel Jones
13. WAS DECEDENT EVER IN U.S. ARMED FORCES (Yes or No): No
14. SOCIAL SECURITY NUMBER: 257-56-9853
15a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
15b. KIND OF INDUSTRY OR BUSINESS: Own Home
16a. RESIDENCE - STATE: Georgia
16b. COUNTY: Paulding
16c. CITY, TOWN or LOCATION: Dallas
16d. STREET AND NUMBER: 412 Hardee St.
16e. INSIDE CITY LIMITS? (Yes or No): Yes

Usual Residence Where Deceased Lived. If Death Occurred in Institution, See Handbook Regarding Completion of Residence Items.

PARENTS

17. FATHER'S NAME (First, Middle, Last): Radford F Sinyard
18. MOTHER'S MAIDEN NAME (First, Middle, Last): Minnie Adair

INFORMANT

19a. INFORMANT'S NAME (First, Middle, Last): Lila A Allison
19b. MAILING ADDRESS (Street, R.F.D. No., City or Town, State, Zip): 6004 Chrisbin Dr. Columbus, GA 31909
19c. RELATIONSHIP: Daughter

DISPOSITION

20a. BURIAL, CREMATION, REMOVAL (Specify): Burial
20b. DISPOSITION DATE (Mo., Day, Year): Nov. 8.1995
20c. CEMETERY OR CREMATORY NAME: Dallas Memory Garden
20d. LOCATION (City or Town, State, Zip, County): Dallas, Ga. 30132 Paulding
21a. FUNERAL DIRECTOR (Signature): [signature]
21b. FUNL DIR. LICENSE NO.: 3107
21c. NAME AND ADDRESS OF FACILITY (Street, R.F.D. No., City or Town, State, Zip): Jeff Eberhart Funeral Home, 123 Watson Drive/P.O.Box 676, DALLAS, GA 30132, 770-445-4496
21d. EST. LICENSE NO.: 1103
21e. EMBALMER (Signature): [signature]
21f. EMBALMER LICENSE NO.: 2659

CAUSE OF DEATH

Conditions, if Any, which Gave Rise To Immediate Cause Stating The Underlying Cause Last.

22. (Enter only one cause per line for A, B, and C)

PART I
A. CVA — Approximate interval between onset and death: 1 12 hours
Due to, or as a consequence of:
B. Carotid Stenosis and — Approximate interval between onset and death:
Due to, or as a consequence of:
C. Atrial Fibrillation — Approximate interval between onset and death:

PART II
24. OTHER SIGNIFICANT CONDITIONS - conditions contributing to death but not related to cause given in Part IA. - (If female, indicate if pregnant or birth occurred within 90 days of death.)
Cliff c Pulmonary Edema NIDDM
25a. AUTOPSY (Yes or No): No
25b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH? (Yes or No):
26a. WAS OPERATION PERFORMED? (Yes or No): NO
26b. DATE OF OPERATION (Mo., Day, Year):
26c. CONDITIONS FOR WHICH OPERATION WAS PERFORMED (Specify):
27. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify):
28a. DATE OF INJURY (Mo., Day, Year):
28b. DESCRIBE HOW INJURY OCCURRED:
28c. HOUR OF INJURY: M
28d. INJURY AT WORK? (Yes or No):
28e. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.)(Specify):
28f. LOCATION (Street, R.F.D. No., City or Town, State, Zip, County):

CERTIFIER

To Be Completed By CERTIFYING PHYSICIAN ONLY

29a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title): Wayne Templeton MD
29b. DATE SIGNED (Mo., Day, Year): Nov. 11, 1995
29c. HOUR OF DEATH: 12:15p M
29d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER:

To Be Completed By MEDICAL EXAMINER OR CORONER ONLY

30a. 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) stated. (Signature and Title):
30b. DATE SIGNED (Mo., Day, Year):
30c. HOUR OF DEATH: M
30d. DATE PRONOUNCED DEAD (Mo., Day, Year): ON
30e. HOUR PRONOUNCED DEAD: AT

TYPE OR PRINT

31a. NAME, TITLE, AND LICENSE NO. OF CERTIFIER (Physician, Medical Examiner, or Coroner): Wayne Templeton, Dr.
PHYS. LIC. NO.: 199416710
31b. ADDRESS OF CERTIFIER (Street, R.F.D. No., City or Town, State, Zip): 1790Mulkey/St8A Austell GA 30001

REGISTRAR

32a. REGISTRAR (Signature): [signature]
32b. DATE RECEIVED BY REGISTRAR (Mo., Day, Year): NOV 17 1995

DO NOT FOLD THIS CERTIFICATE

VS 3903 (Rev.9-91) GEORGIA DEPARTMENT OF HUMAN RESOURCES / VITAL RECORDS SERVICE

"CERTIFICATE OF RECORD"

THIS IS AN EXACT COPY OF THE DEATH CERTIFICATE RECEIVED FOR FILING IN COBB COUNTY, GEORGIA.

[signature]
LOCAL CUSTODIAN

BY [signature]
LOCAL CUSTODIAN OFFICE

DATE NOV 17 1995
(SEAL)