Susie E. Gaffney

Name of Deceased

USUAL RESIDENCE

State Fla County Walton

City

Street Address R 8, Box 954, DFS

Time in Walton County or D.F.S.

PLACE OF DEATH

State Fla County W

City DFS

Name of Hospital Valley Spgs

Length of stay in hospital

Date of Death 10 25 85

Month Day Year Hour

Married Never Married

Sex F Widowed Divorced

Date of Birth 1900 Age 84

Birthplace La

Usual Occupation

Business or Industry

Name of Spouse

Maiden name if wife

Father's Name

Mother's Maiden Name

Informant

Address

Physician Koppman

Address

Church Affiliation

Fraternal Affiliations

In U.S. Armed Forces

Social Security No. 267-20-0590

Date of Funeral Hour

Place of Funeral

Minister

Music

Cemetery

PALLBEARERS

1203 N. 69th Ave
Pensacola 3250

1 copy

478-3292

SURVIVORS

Spouse

Father

Mother

Daughters:

Sons

Sisters

Brothers

Grandchildren

Great Grandchildren

Meet Family

Place

Time

Family Telephone

Start Repose Family Friends

Cards — Pull - - - - - - - - Leave

Mark Grave

Grave Marker — Yes No

Call Rustin — Vault Up Down

Call Escort Jake Organist

Paper — Obit

Discharge papers (if Vet)

Hair Style

Facial Hairs Pull Leave

Jewelry

Glasses

Tissue Builder

TYPE OR PRINT **PERMANENT** BLACK INK SEE HANDBOOK FOR INSTRUCTIONS

CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO.

DECEDENT

1. DECEDENT—NAME FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Mo. Day, Yr.)
Susie	Edna	Gaffney	Female	October 25, 1985

4. RACE—e.g., White, Black Am. Indian, etc. (Specify)	5a. AGE—Last Birthday (Yrs.)	UNDER 1 YEAR 5b. MOS. / DAYS	UNDER 1 DAY 5c. HOURS / MINS.	6. DATE OF BIRTH (Mo., Day, Yr.)	7a. COUNTY OF DEATH
White	85			August 7, 1900	Walton

7b. CITY, TOWN OR LOCATION OF DEATH	7c. HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number)	7d. IF HOSP. OR INST. (Indicate DOA, OP/Emer. Rm., Inpatient (Specify)
DeFuniak Springs	Valley Springs Community Hospital	Inpatient

8. STATE OF BIRTH (If not in U.S.A., name country)	9. CITIZEN OF WHAT COUNTRY	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)
Louisiana	U.S.A.	Widowed	

12. SOCIAL SECURITY NUMBER	13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	13b. KIND OF BUSINESS OR INDUSTRY
267-20-0590	Housewife	Own Home

PARENTS

14a. RESIDENCE—STATE	14b. COUNTY	14c. CITY, TOWN OR LOCATION	14d. STREET AND NUMBER	14e. INSIDE CITY LIMITS (Specify Yes or No)
Florida	Walton	DeFuniak Springs	Freeport Highway	No

15. FATHER—NAME FIRST	MIDDLE	LAST	16. MOTHER—MAIDEN NAME FIRST	MIDDLE	LAST
Albert		O'Neil	Cathrine		Green

DISPOSITION

17a. INFORMANT—NAME (Type or Print)	17b. MAILING ADDRESS STREET OR R.F.D. NO.	CITY OR TOWN	STATE	ZIP
Adrian Moore	1203 North 69th Avenue	Pensacola	Fla.	32506

18a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	18b. CEMETERY OR CREMATORY—NAME	18c. LOCATION CITY OR TOWN	STATE
Burial	Union Hill Cemetery	Pensacola, Florida	

19a. FUNERAL DIRECTOR—(Signature) ▶	19b. FUNERAL HOME	ADDRESS
Robert M. Comander	Comander Funeral Home, DeFuniak Springs, Florida	3 West Main Street, 32433

CERTIFIER

To be Completed by CERTIFYING PHYSICIAN Only

20a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.
(Signature and Title) ▶ Dennis W. Korpman MD

20b. DATE SIGNED (Mo., Day, Yr.)	20c. HOUR OF DEATH
10/28/85	11:44 A.M M

20d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To be Completed by MEDICAL EXAMINER

21a. 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) ▶

21b. DATE SIGNED (Mo., Day, Yr.)	21c. HOUR OF DEATH
	M

21d. PRONOUNCED DEAD (Mo., Day, Yr.) ON	21e. PRONOUNCED DEAD (Hour) AT
	M

22. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or print)
Dennis Korpman, M.D., Warren Plaza, College Avenue, DeFuniak Springs, Fla. 32433

REGISTRAR 23a. (Signature) ▶	23b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)
Sub-Registrar	

CAUSE OF DEATH

24. IMMEDIATE CAUSE [ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).]

PART I
(a) Cardiorespiratory Arrest — Interval between onset and death: Immed
DUE TO, OR AS A CONSEQUENCE OF: (Condition(s) which gave rise to cause (a) — List underlying cause last)
(b) Myo Cardial Infarction — Interval between onset and death: Immed
DUE TO, OR AS A CONSEQUENCE OF:
(c) — Interval between onset and death:

PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)

PART III IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? Yes ☐ No ☒

25. AUTOPSY (yes or no): No

26. CASE REFERRED TO MEDICAL EXAMINER (Specify yes or no): No

27a. (Probably) ACCIDENT, SUICIDE or HOMICIDE; or UNDETERMINED (Specify)	27b. DATE OF INJURY (Mo., Day, Yr.)	27c. HOUR OF INJURY M	27d. DESCRIBE HOW INJURY OCCURRED

27e. INJURY AT WORK (Specify Yes or No)	27f. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	27g. LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE

State of Florida, Department of Health and Rehabilitative Services, Vital Statistics

HRS Form 512, Jul 84 (Obsoletes previous editions as of 12-31-84

ADMISSION INFORMATION

MEDICAL CHART

LAST NAME	FIRST NAME	M.I.	PATIENT NUMBER	ADMISSION DATE & TIME
NEY	SUSIE	E	00448	7-19-85; 10AM

PATIENT'S ADDRESS — STREET, CITY, STATE, ZIP	TELEPHONE NUMBER
. 8 Box 954, DeFuniak Springs	

DATE	AGE	BIRTH PLACE	SEX	RACE	CITIZENSHIP	RELIGION	MARITIAL STATUS (M S D W Z SEP)	ROOM	BED
1900	84	LA	F	Cau	USA	Baptist		104	1

ATTENDING PHYSICIAN(S)	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
J. D. Lawlor	892-5104		DeFuniak Springs,	Fla.	
CONSULTING PHYSICIAN	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
Dennis Korpman	892-5104		DeFuniak Springs,	Fla.	
REFERRING PHYSICIAN	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
ATTENDING DENTIST	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
J. Briscoe	892-3634	Circle Dr.	DeFuniak Springs,	Fla.	
PHARMACY OF CHOICE (INIT.)	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
vice Drugs x	892-5911	BaldwinAve	DeFuniak Springs,	Fla.	
PODIATRIST OF CHOICE (INIT.)	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
NEXT OF KIN — IN EMERGENCY	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
lyn Gandy	892-5481		DeFuniak Springs,	Fla.	
NEXT OF KIN - IN EMERGENCY	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
RESPONSIBLE PARTY (Conservator, etc.)	TELEPHONE NO.	ADDRESS	CITY	STATE	ZIP
Evelyn Gandy	892-5481	Rt. 8 Box 1064	DeFuniak Springs	Fla.	

PRINCIPAL DIAGNOSIS	ICDA PRIMARY	MEDICARE NO.
generative dementria;anemia		267-20-0590-A (A&B)
	ICDA SECONDARY	MEDICAID/MEDICAL NO.
ALLERGIES		SOCIAL SECURITY NUMBER

HOSPITAL ADMITTED FROM (Qualifying Hospital Stay)	DATE OF QUALIFYING STAY (Medicare) Admitted	Discharged
OTHER PRIOR HOSPITAL/SNF STAY INFORMATION		

OCCUPATION	FATHER'S NAME	MOTHER'S MAIDEN NAME	MILITARY SERVICE — DATES (If available)
etired	P. A. O'Neil	Catherine Green	

BILLING DATA

GT (Name)	LAUN	Y	N	INITIAL PATIENT TYPE	CODE	SECONDARY PATIENT TYPE	CODE
			X				
GT (address line 1)				PVT. CONTRACT RATE $	CODE	ESTIMATED LIABILITY $	
GT (address line 2)				BLUE CROSS CONTRACT NO.		THIRD PARTY I.D. NUMBER	
GT (address line 3)	BEAUTY			WELFARE CASE WORKER		TELEPHONE NO.	

MEDICAID Applicable	MEDI-CARE STATUS CODE	MEDI-CARE BENEFITS Exhausted Date	I.D. CARD REC'D ON ADMISSION Yes No	ATTENDING PHYSICIAN'S STATE LICENSE NUMBER	V.A. NUMBER	PRIOR PATIENT

INSTRUCTIONS: 1. Shaded information MUST be obtained upon admission.
2. Distribute Chart Copy to nursing on day of admission.

DISCHARGE INFORMATION

FUNERAL DIRECTOR	TELEPHONE
MARY-GODWIN Funeral Home, DeFuniak Springs	892-2511

DISCHARGE DIAGNOSIS (1.)	
DISCHARGE DIAGNOSIS (2.)	

DISPOSITION	ICDA CODE	DISCHARGE DATE
ATTENDING NURSE NAME	ATTENDING PHYSICIAN SIGNATURE	PATIENT NUMBER

Hospital

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

SUSIE E GAFFNEY

CLAIM NUMBER | SEX

267-20-0590-A | FEMALE

IS ENTITLED TO | EFFECTIVE DATE

HOSPITAL INSURANCE | 7-1-66

MEDICAL INSURANCE | 7-1-66

SIGN HERE ▷ Susie E. Gaffney.

267-20-0590

SOCIAL SECURITY ACCOUNT NUMBER

SUSIE EDNA MOORE
28282 W. DE SOTO ST.
PENSACOLA, FLA.

WORKER'S NAME AND HOME ADDRESS

EMPLOYER'S NAME
UNEMPLOYED

IF WORKER'S NAME IS CHANGED MAKE REQUEST FOR ACCOUNT NUMBER CARD BEARING NEW NAME ON FORM OAAN-700$ WHICH MAY BE SECURED FROM ANY SOCIAL SECURITY BOARD FIELD OFFICE.