

STATE OF *VIRGINIA*
COUNTY OF *FAIRFAX*

PERSONALLY appeared before me, the undersigned authority in and for the said county and state, on this the 22 day of September, 2000, within my jurisdiction, the within named CATHERINE LYNN SANDIFER, who acknowledged that she executed the above foregoing instrument.



My Commission Expires: *Aug 31, 2003*

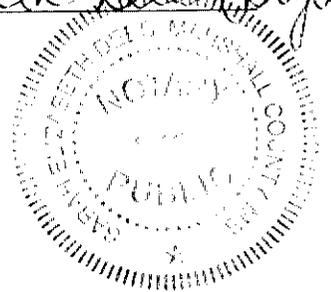
[Signature]

Notary Public

STATE OF Mississippi
COUNTY OF DeSoto

PERSONALLY appeared before me, the undersigned authority in and for the said county and state, on this the 26th day of September, 2000, within my jurisdiction, the within named JOHN MICHAEL SANDIFER, who acknowledged that he executed the above foregoing instrument.

[Signature: Sarah Elizabeth Deason (Byjoil)]
Notary Public



My Commission Expires:
June 21, 2003

GRANTOR'S ADDRESS:
3650 Woodland Drive
Horn Lake, MS 38637

GRANTEE'S ADDRESS:
3650 Woodland Drive
Horn Lake, MS 38637

Work #: 901-396-3786
Home #: 662-393-2320

Work #: 901-396-3786
Home #: 662-393-2320

This Instrument Prepared By:
Eric L. Sappenfield
97 Stateline Rd., East Suite A
Southaven, MS 38671
662/342-2170

STATE OF MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH VITAL RECORDS

TYPE OR PRINT
IN BLACK INK

FILING DATE **JUL 11 1991**

CERTIFICATE OF DEATH
STATE OF MISSISSIPPI

STATE FILE NUMBER **123-91-10354**

DECEASED

1. NAME First Middle Last **Billy G. Sandifer** 2. SEX **MALE** 3a. HOUR OF DEATH **5:17 A** 3b. DATE OF DEATH (Month, Day, Year) **June 19 1991**

4. RACE (Specify White, Black, American Indian, etc.) **WHITE** 5a. AGE AT LAST BIRTHDAY **49** Years 5b. MOS **0** 5c. DAYS **0** 5d. HOURS **0** 5e. MINS **0** 6. DATE OF BIRTH (Month, Day, Year) **8/10/1941** 7a. COUNTY OF DEATH **Desoto**

Death occurred in institution, see ANOBOOK regarding completion of SILENCE items

7b. CITY OR TOWN OF DEATH **Southaven, Ms.** 7c. HOSPITAL OR OTHER INSTITUTION NAME AND NUMBER (If not inpt., give street address, route number, or other location) **Baptist Hosp. Desoto/Southcrest Pkwy.** 7d. # IN HOSP. OR INST. SPECIFY INPT., OUTPT., EMER RM OR OOA **Inpt.** 8. STATE OF BIRTH **MS**

RESIDENCE Items for actual location home rather than mailing address

9. DECEDENT'S EDUCATION (Specify only highest grade completed) **12** 10. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) **MARRIED** 11. SURVIVING SPOUSE (If w/w, give maiden name) **CAROL PRICE** 12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes - No) **YES**

13. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.) **AMERICAN** 14. SOCIAL SECURITY NUMBER **428 84 7440** 15a. USUAL OCCUPATION (Kind of work done, most of working life) **EQUIPMENT SERVICE** 15b. KIND OF BUSINESS OR INDUSTRY **NORTHWEST AIRLINES**

16a. RESIDENCE - STATE **MS** 16b. COUNTY **DESOTO** 16c. CITY OR TOWN **HORN LAKE** 16d. INSIDE CITY LIMITS (Specify Yes or No) **YES** 16e. STREET AND NUMBER OR RURAL LOCATION **3650 WOODLAND DR.**

PARENTS

17. FATHER - NAME First Middle Last **TROY L. SANDIFER** 18. MOTHER - NAME First Middle Maiden **MARGARET COGDELL**

INFORMANT

19a. INFORMANT - NAME (Type or print) **TROY L. SANDIFER** 19b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) **3650 WOODLAND DR. HORN LAKE, MS 38637**

DISPOSITION

20a. BURIAL, CREMATION, REMOVAL (Specify) **BURIED** 20b. CEMETERY, CREMATORY - NAME **FOREST HILL CEM.** 20c. LOCATION (City and State) **MEMPHIS, TN** 21a. EMBALMER - SIGNATURE AND NUMBER

21b. FUNERAL HOME - NAME AND MISSISSIPPI I.D. NUMBER **FOREST HILL FUNERAL HOME** 21c. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) **P.O. BOX 34577 MEMPHIS, TN 38184**

PRONOUNCEMENT

22a. PERSON WHO PRONOUNCED DEATH - NAME AND TITLE (Type or print) **Sara Schrader, M.D.** 22b. PRONOUNCED DEAD (Month, Day, Year) **on June 19, 1991** 22c. PRONOUNCED DEAD (Hour) **15:17** 22d. **A** m.

CERTIFIER

23a. CERTIFIER - NAME (Type or print) **CLAUDE P. LEDES** 23b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code) **5700 Park Ave Memphis TN 38119**

Mississippi State Board of Health Form No. 511 Rev. 1-1-89

This section to be completed by physician if NOT a medical examiner 24a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated. **CLAUDE P. LEDES MD** 24b. DATE SIGNED (Month, Day, Year) **6/19/91** 24c. STATE LICENSE NUMBER **5637** 24d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or print) 24e. On the basis of examination and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated. **CLAUDE P. LEDES MD** 24f. TITLE 24g. DATE SIGNED (Month, Day, Year)

CAUSE OF DEATH

25. PART I: IMMEDIATE CAUSE (Enter one cause only) (a) **Brain Metastases** Interval between onset and death **3 mos** (b) **Metastatic Bronchogenic Carcinoma** Interval between onset and death **7 years** (c) DUE TO OR AS A CONSEQUENCE OF (Enter one cause only) 26. PART II: OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I 27. AUTOPSY (Yes or No) **NO** 28. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No) **NO**

Conditions, if any, which gave rise to immediate cause stating the underlying cause last

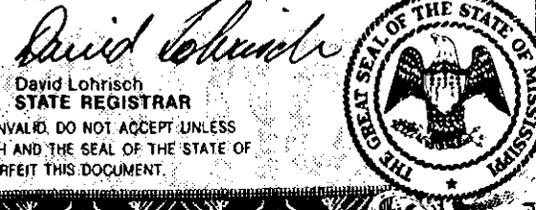
29a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify) 29b. DATE OF INJURY (Month, Day, Year) 29c. HOUR OF INJURY m. 29d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED 29e. INJURY AT WORK (Yes or No) 29f. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.) 29g. LOCATION Street or route number City or town State

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE



Alton B Cobb, M.D.
Alton B. Cobb, M.D.
STATE HEALTH OFFICER

July 25, 1991



WARNING: A REPRODUCTION OF THIS DOCUMENT RENDERS IT VOID AND INVALID. DO NOT ACCEPT UNLESS EMBOSSED SEALS OF THE MISSISSIPPI STATE BOARD OF HEALTH AND THE SEAL OF THE STATE OF MISSISSIPPI ARE PRESENT. IT IS ILLEGAL TO ALTER OR COUNTERFEIT THIS DOCUMENT.