



TENNESSEE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

PRINT IN PERMANENT INK FOR DUPLICATIONS AND BOOKS

1. DECEDENT'S NAME (First, Middle, Last) Joseph Meziere				2. SEX Male	3. DATE OF DEATH (Month, Day, Year) October 31, 2003	
4. SOCIAL SECURITY NUMBER (of Decedent) 434-54-0030	5a. AGE-LAST BIRTHDAY (Years) 67	5b. UNDER 1 YEAR MO. DAYS	5c. UNDER 1 DAY HOURS MIN.	6. DATE OF BIRTH (Month, Day, Year) October 7, 1936	7. BIRTHPLACE (City and State or Foreign Country) Campiti, Louisiana	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		9a. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
9b. FACILITY NAME (If not institution, give street and number) Baptist Memorial Hospital - Memphis		9c. CITY, TOWN, OR LOCATION OF DEATH Memphis		9d. COUNTY OF DEATH Shelby		
10. MARITAL STATUS Married, Never Married, Widowed, Divorced (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Alice Williams	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Construction Worker		12b. KIND OF BUSINESS/INDUSTRY Ronald S. Terry Construction		
13a. RESIDENCE-STATE Mississippi	13b. COUNTY DeSoto	13c. CITY, TOWN OR LOCATION Horn Lake	13d. STREET AND NUMBER OR RURAL LOCATION 2995 Greenbriar Cove West			
13e. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		13f. ZIP CODE 38637	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		15. RACE-American Indian, Black, White, etc. (Specify) White	
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 			17. FATHER'S NAME (First, Middle, Last) Joseph Leo Meziere			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Sanchez			19a. INFORMANT'S NAME (Type/Print) Alice Williams Meziere			
19b. RELATIONSHIP TO DECEASED Wife			19c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2995 Greenbriar Cove West Horn Lake, MS 38637			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Twin Oaks Memorial Gardens		20c. LOCATION-City or Town, State Southaven, Mississippi		
21a. SIGNATURE OF FUNERAL DIRECTOR <i>Regina K Peabler</i>		21b. LICENSE NUMBER OF FUNERAL DIRECTOR FS-789	21c. SIGNATURE OF EMBALMER <i>Regina K Peabler</i>		21d. LICENSE NUMBER OF EMBALMER FS-789	
22a. NAME AND ADDRESS OF FUNERAL HOME Twin Oaks Funeral Home 290 Goodman Road East Southaven, MS 38671				22b. LICENSE NUMBER OF FUNERAL HOME 429		
23. REGISTRAR'S SIGNATURE <i>Alice Williams</i> Deputy			24. DATE FILED (Month, Day, Year) NOV 17 2003			
25. PHYSICIAN - To the best of my knowledge, death occurred at the date and place, and due to the cause(s) and manner as stated.						
1 <input type="checkbox"/> SIGNATURE AND TITLE OF PHYSICIAN <i>Arnel Pallera MD</i>		25b. LICENSE NUMBER 30872	25c. DATE SIGNED (Month, Day, Year) 11/10/03			
26a. MEDICAL EXAMINER - On the basis of examination and/or investigation, in my opinion, death occurred at the date and place, and due to the cause(s) and manner as stated.						
2 <input type="checkbox"/> SIGNATURE AND TITLE OF MEDICAL EXAMINER		26b. LICENSE NUMBER	26c. DATE SIGNED (Month, Day, Year)			
27. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR MEDICAL EXAMINER) (Type/Print) Dr. Arnel Pallera 100 North Humphreys Suite 100 Memphis, TN 38120						
28. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia					1 week	
DUE TO (OR AS A CONSEQUENCE OF):						
b. Small cell lung cancer					1 month	
DUE TO (OR AS A CONSEQUENCE OF):						
c. _____						
DUE TO (OR AS A CONSEQUENCE OF):						
d. _____						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
29a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
30. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be Determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		31a. DATE OF INJURY (Month, Day, Year)	31b. TIME OF INJURY	31c. INJURY AT WORK? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	31d. DESCRIBE HOW INJURY OCCURRED	
31e. PLACE OF INJURY-At home, farm, street, factory, office building, etc. (Specify)			31f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

DECEDENT

CENSUS TRACT

PARENTS

INFORMANT

DISPOSITION

REGISTRAR

PHYSICIAN

MEDICAL EXAMINER

IAN OR MEDICAL EXERCISING STATE MUST SIGN AND SIGNATURE CERTIFICATION 48 HOURS.

INSTRUCTIONS OTHER SIDE

CAUSE OF DEATH