I-7.2 SE ¼

FLORIDA DEPARTMENT OF HEALTH

**State of Florida, Department of Health, Vital Statistics**
**APPLICATION FOR BURIAL - TRANSIT PERMIT**

A. (TYPE)

| | | | | | |
|---|---|---|---|---|---|
| 1. Name of Deceased | First: EVELYN | Middle: JUNE | Last: LOVELL | Date of Death: Month Day Year | SEPT. 1, 2002 |
| 2. Place of Death — County: ST. LUCIE | City, Town or Location: PT. ST. LUCIE | Name of Hosp. or Inst. (If neither, give street address): ST. LUCIE MEDICAL CENTER | | | |
| 3. Name of Medical Certifier: MANUEL GONZALEZ — [ ] Medical Examiner [X] Physician | Address: 1801 S.E. HILLMOR DR. PT. ST. LUCIE, FL 34952 | Phone Number: 772-335-3500 | | | |
| 4. Name of Funeral Home/Direct Disposal Establishment: ATLANTIC MORTUARY | Address: P.O.BOX560433 ROCKLEDGE, FL 32956 | Fla. Lic. No./Reg. No.: 2614 | Phone No. (Area Code): 321-633-3002 | | |

5. Check Appropriate Box

a. [ ] The medical certification has been completed and signed. A completed certificate of death accompanies this application.

b. [X] DR. GONZALEZ was contacted on 9/1. He/she verified that this death was from natural causes, that there was no accident nor other external cause of death and that he will complete and sign the medi certification of cause of death within 72 hours.

c. [ ] _____ was contacted on _____. He/she verified th _____, Medical Examiner, will complete and sign medical certification of cause of death within 72 hours.

6. Funeral Director/ Signature F.E. No./Reg. No. Date Signed