CERTIFICATE OF DEATH/STATE OF GEORGIA

Birth Number

Local File Number 008881

State File Number 039726

1a. DECEDENT'S NAME (First, Middle, Last): Thomas Francis HOBSON, Jr.

1b. IF DECEDENT IS FEMALE, ENTER MAIDEN LAST NAME:

2. SEX: Male

3. DATE OF DEATH (Mo., Day, Year): September 24, 1991

4. RACE (White, Black, Amer. Indian, etc.) (Specify): White

5. ORIGIN OF DECEDENT (Italian, Mex., French, English, etc.): Unknown

6. DATE OF BIRTH (Mo., Day, Year): Sept. 5, 1938

7a. AGE Last Birthday (Years): 53

7b. UNDER 1 YEAR: Mos. / Days

7c. UNDER 1 DAY: Hours / Mins.

8a. COUNTY OF DEATH: Fulton

8b. CITY, TOWN or LOCATION OF DEATH: East Point ~~Atlanta~~

9a. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and No.): South Fulton Hospital

9b. IF HOSPITAL OR INST. (Indicate DOA, OP/EMER. Rm., Inpatient) (Specify): Inpatient

10a. STATE AND COUNTY OF BIRTH (If not in USA, name Country): CA/Sonoma

10b. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

12. SPOUSE (If married or widowed, give spouse's name—if wife, give maiden name):

13. WAS DECEDENT EVER IN U.S. ARMED FORCES (Yes or No): No

14. SOCIAL SECURITY NUMBER: 565-48-3829

15a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman

15b. KIND OF INDUSTRY OR BUSINESS: Musical Instruments 05200

16a. RESIDENCE – STATE: Georgia

16b. COUNTY: Fulton

16c. CITY, TOWN or LOCATION: Atlanta

16d. STREET AND NUMBER: 1020 Eden Avenue

16e. INSIDE CITY LIMITS? (Yes or No): Yes

17. FATHER'S NAME (First, Middle, Last): Thomas F. Hobson, Sr.

18. MOTHER'S MAIDEN NAME (First, Middle, Last): Unknown Hanson

19a. INFORMANT'S NAME (First, Middle, Last): Gregory E. Hobson

19b. MAILING ADDRESS (Street, R.F.D. No., City or Town, State, Zip): 1020 Eden Ave., Atlanta, GA 30316

19c. RELATIONSHIP: Son

20a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

20b. DISPOSITION DATE (Mo., Day, Year): Sept. 25, 1991

20c. CEMETERY OR CREMATORY NAME: Atlanta Crematory

20d. LOCATION (City or Town, State, Zip, County): Stone Mountain, GA 30086 Fulton

21a. FUNERAL DIRECTOR (Signature): William P. Hightower

21b. FUN. DIR. LICENSE NO.: 3703

21c. NAME AND ADDRESS OF FACILITY (Street, R.F.D. No., City or Town, State, Zip): Hightower Funeral Home, 318 Gordon Street, Bremen, GA 30110

21d. EMBALMER (Signature): NONE

21e. EMBALMER LICENSE NO.: None

21f. EST. LICENSE NO.: 179

PART I

23. IMMEDIATE CAUSE (Enter only one cause per line for A, B, and C)

	Cause	Approximate interval between onset and death
A.	INTRA CEREBRAL HEMORRHAGE	19 DAYS
B. Due to, or as a consequence of:		
C. Due to, or as a consequence of:		

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.)

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): 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):

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) [signature] MD

29b. DATE SIGNED (Mo., Day, Year): OCT 7 1991

29c. HOUR OF DEATH: 5:40 P. M

29d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER: MARK A. KOZINN MD

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

31a. NAME AND TITLE OF CERTIFIER (Physician, Medical Examiner, or Coroner): Mark A. Kozinn M.D.

31b. ADDRESS OF CERTIFIER (Street, R.F.D. No., City or Town, State, Zip): 1136 Cleveland Avenue, East Point, GA 30344

32a. REGISTRAR (Signature): [signature]

32b. DATE RECEIVED BY REGISTRAR (Mo., Day, Year): OCT 17 1991

This is to certify that this is a true and correct copy of the certificate filed with the Vital Records Service, Georgia Department of Human Resources. This certified copy is issued under the Authority of Chapter 31-10, Vital Records Code of Georgia.

[signature]
State Vital Records
Registrar and Custodian
Director, Vital Records Service

County Custodian [signature]

Issued By: [signature] Date: 1-10-2003

(Void without original signature and impressed seal)