Toole Documents - Sent to Joe Matthews by Sarah Patterson (Niece of Toole) (Adam Walsh) From: Phil Mundy

investigator

State Attorney's Office Phone 305-831-6368

Pager Mobi.

Nov. 14, 1996

To: Ralph Ray, Jr.

These documents were sent to Joe Matthews by Tooles' niece Sarah Patterson and he in turn sent copies to me. I am forwarding them to you just for the file.

201 S.E. 6th Street • Fort Lauderdale, FL 33301

Affidavit of Execution and Attestation

I sign my name to this, my Will, and being duly sworn, declare that I sign voluntarily for the purposes expressed therein, and am of lawful age, of sound mind and under no undue influence.
X O The Tools (Testator)
The undersigned witnesses being duly sworn, each declares that the Testator signed this Will consisting of one page with writing on both sides thereof, at the end thereof, and on each side thereof, in our presence, and signified, published and declared in our presence that this instrument is his/her Last Will and Testament, and that at the request of and in the presence of Testator and in the presence of each other and in the presence of a Notary Public each has subscribed his/her name to this Will as witness to Testator signing this 3044 day of 1995, and to the best of his/her knowledge Testator is of lawful age, of sound mind and under no undue influence.
(1) Better F Glanley residing at Alaste, Flanda
(2) Merrall C. Marte residing at Hacke, Flacida
Steresa K. Dowling residing at Starke, Glorida
State of Florida
County of Bradford City or Town Starke
Subscribed, sworn to and acknowledged before me by the Testator Deltas Toole
and Beline R. Stanley and Verrell C. martin and
Teres . K. Dowling the witnesses, this 30th day of August 1995

Page two of two pages

FROM 9544342661

GEORGE D. HALL Notary Public, State of Florida

My Comm. expires Dec. 27, 1996 Comm. No. CC 248210

(Seal)

T-5 1 1.

1-08-98 04:30 FM F1

Last Will and Testament

Unmarried Individual with One Beneficiary

I, OTTIS ELWOOD	TOOLE #090812 presently residing at
FLORIDA STATE PRISON, P.O.BOX 747, S	•
	Last Will and Testament and do hereby revoke any and all
	ereby give all my estate to the following named person:
SARAH CHRISTINE	PATTERSON
Second. In the event that the said	
I give all of my estate to	N/A
Third. I order and direct that my just debestate and any inheritance and succession taxes, st death as may be practical.	ts and funeral expenses, expenses for administration of my ate or federal, upon my estate shall be paid as soon after my
Fourth. A nominate and appoint	SARAH CHRISTINE PATTERSON
as Executor/ Executrix of this Will. In the event the to serve as Executor/ Executrix then I nominate	nat he/she shall predecease me or fails to survive me or fails
Executor, Executive of this my Last Will and Test required to give any bond for the faithful perfort	ament. I further direct that no appointee hereunder shall be
and immunities conterred upon fiduciaries to the	xecutrix to exercise all the powers, rights, discretions, duties are extent permitted by law with full power to sell, lease, of the assets of my estate, including my remains.
I subscribe my name to this Will this	30th Day of August 19 90
	Day of August 19 95 (Sign here)
105tator in the presence of us, who in his/her pro-	be his/her Last Will and Testament by the within named esence and at his/her request, and in the presence of each tnesses this day of August, 19.25 of Ata la Hay la Hay la
Alresa K. Dowling	of Starke Storida (State) (City) (State)
	•
Page one of	TVO DOCOG
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	I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:
PRINT THE	Name:
NAMES AND ADDRESSES OF	Address:
HOSE WHO YOU WANT TO KEEP	Name:
COPIES OF THIS	Address:
	X Signed: OTTIS Toole Otto Toole
3IGN AND DATE THE DOCUMENT	X Date: 9-26-95
	\wedge Date: $/- \times 6$
WITNESSING	
PROCEDURE	
Two witnesses	Witness 1:
MUST SIGN AND	Signed Daviel Sames Wells Address: 747 STARKE, FloRICA 32091
ADDRESSES	Address: 147 STARKE, FloRICA 32091
1	
	Witness 2:
	Signed: hales Hown Address: Po Box 747 Tracks Local
	3909/
-150 Auto-	PAGE 2 FROM 9644343667

INSTRUCTIONS

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

PRINT YOUR

OTTIS TOOLE #090812

5-2 N-7

FLORIDA STATE PRISON P.O.BOX 747 STARKE

STARKE FL 3

32091-0747

(Last)

Name:

(First)

(Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

Name: SARAH CHRISTINE PATTERSON

Address: 217 - 16th Ave North #B

JACKSONVILLE BEACH FL Zip Code: 32250-7434

Phone: 904-249-9064

If my surrogate is unwilling or unable to perform his duties, I wish to designate as my alternate surrogate:

PRINT THE
NAME, HOME
ADDRESS AND
TELEPHONE
NUMBER OF
YOUR
ALTERNATE
SURROGATE

Name:

 Address:
 ______ Zip Code: ______

Phone:

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

ADD PERSONAL INSTRUCTIONS (IF ANY) Additional instructions (optional):

FROM 9544342567

(500년)

11-06-96 04:32 PM PD8

	I wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on my behalf:
PRINT NAME,	Name:Address:
AND TELEPHONE NUMBER OF	Zip Code:
YOUR ALTERNATE SURROGATE	Phone:
ADD PERSONAL INSTRUCTIONS (IF ANY)	Additional instructions (optional):
SIGN THE DOCUMENT	I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. X Signed: 9-26-95.
WITNESSING PROCEDURE Two witnesses Must sign and	
PRINT THEIR ADDRESSES	Witness 2: Signed: halls Hon Address: Do. Box 747 STARK? J. 3209/

INSTRUCTIONS

FLORIDA LIVING WILL

-	ĸ	i teri	INE	ואע

DATE X Declaration made this 26 day of September, 1995.

PRINT YOUR NAME

OTTIS TOOLE #090812 Florida State Prison S-2 N-7

I, P.O.BOX 747 STARKE FL 32091-0747 , willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

PRINT THE
NAME, HOME
ADDRESS AND
TELEPHONE
NUMBER OF
YOUR
SURROGATE

Name: SARAH CHRISTINE PATTERSON

Address: 217 North 16th Ave #B

JACKSONVILLE BEACH FL Zip Code: 32250-7434

Phone: 904-240-9064



BOX A OR B MUST BE COMPLETED

. اسپرس	PATIEN	T'S SIGNATURE	
I, the understaned.	hereby direct that in the event of my cardiac or result.	story arrest, efforts at cardiopulmonary resuscitation not be initiated. To	unda.
that I may revoke the	nese directions at any time by physical cancellation o	r destruction of this form and the accompleming bracelet, or by praily	axore
a desire to be resu:	scitated to EMS personnel; or by means of a subsequ	antiv executed advance directive that is mot trially different from this o	rder.
understand that if E	IMS personnel have any doubts about the applicabil	ty or validity of this order, they will begin · · · Sopulmonary resuscitation	D.
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*WITNESSES:			
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		HE OR COURT METURISS SUBSTILIAR OR PROAT	
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FROM 9544343667

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DO NOT RESUSCITATE

Florida

hospital ، ehospital	Do Not Resuscitate	Order (DNRO)

	(Please Pri	nt or Type)
	ATTENDING PH	YSICIAN'S ORDER
a undersign e patient na	led, a physician \mathbb{R}^2 ensed pursuant to Chapter 458 amed above. I have documented in the patient's	or 459, Florida Statutes (F.S.), state that I am the attending physic medical record that: (must check 1 or 2)
1.	The patient is CAPABLE of making an informed a specific medical treatment or course of treatment.	ed decision and consent about providing, withholding or withdraw tent. (Signature of patient is required in Box A, reverse side).
2.	of the propose " "edical decision, or to make a re-	ted dacision and consent about providing, withholding or withdraw is unable to understand the nature, extent or probable consequence tional evaluation of the risks and benefits of alternatives to that decision in with a second physician licensed under Chapter 456 or 459, F.S.
x 2 above is	s checked, (patient is INCAPABLE of making an i	nformed decision), either 1, 2, or 3 below must be checked;
1 .	The patient has executed a written advance d withdrawn (Signature of surrogate or proxy or gridinative must be attached).	Irective which directs that life-prolonging procedures be withheld lardian is required in Box B, reverse side and a copy of the advan
2.	F.S., to make high care decisions on behalf of prolonging procedures be withheld or withdrawn.	ictive which appoints a health care surrogate pursuant to Chapter 7
	and a copy of the advance directive must be at	
] 3.	The patient has NOT executed a written advence	ached). directive (living will, designation of a health care surrogate or dura
d upon the nnel, comm ation, and ot	The patient has NOT executed a written advance power of attorney for health care). (Signature of 765, Part IV, F.S., is required in Box B, reverse informed directive, decision and consent on the reacting on the effective date noted above, to withher advanced airway management, artificial world.	ached). directive (living will, designation of a health care surrogate or dura f guardian, if one has been appointed, or proxy, pursuant to Chapside). everse side, I hereby direct any and all emergency medical service old cardiopulmonary resuscitation (cardiac compression, endotrach tion, defibrillation and related procedures) from the patient in the everse.
d upon the nnel, comm ation, and of patient's co enous fluids	The patient has NOT executed a written advance power of attorney for health care). (Signature of 765, Part IV, F.S., is required in Box B, reverse informed directive, decision and consent on the reacting on the effective date noted above, to withher advanced airway management, artificial ventilal ardiac or respirating arrest. I further direct such personal content of the respiration of the	chighature of the appointed surrogate is required in Box 5, reverse sached). Indirective (living will, designation of a health care surrogate or dural figuration, if one has been appointed, or proxy, pursuant to Chap side). Everse side, I hereby direct any and all emergency medical service in the compression, endotrached cardiopulmonary resuscitation (cardiac compression, endotrached cardiopulmonary resuscitation (cardiac compression, endotrached cardiopulmonary resuscitation (cardiac compression, endotrached provide to provide to the patient other medical interventions, such to provide comfort care or to alleviate pain.
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\$ Form 1896, Oct 93 :4-667 (4/94)

THIS SIDE MUST BE COMPLETED

(OVER)

FROM 9544342667.

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11-06-95 04:32 PM FD4

STATE OF FLORIDA DEPARTMENT OF CORRECTIONS

Designation of Health Care Surrogate

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tment and surgical and diagnos	tic procedures, I wish to designat	e as my surrogate for health care decisions:
ne: Sava Patters	· <u>~ </u>	
iress: 217 N. 16th Ave, Apa	tment B.	
•	Zip Code:	3220
ne:	·	
If my surrogate is unwilling togate:	ng or unable to performed his o	luties, I wish to designate as my alternate
ne:		
iress:		
	Zip Code:	
one:		
I further affirm that this des facility. I will notify and sen hey may know who my surroga	ignation is not being made as a cod a copy of this document to the	ondition of treatment or admission to a health following persons other than my surrogate,
ne;		
ne:		
ned: Otwo	y oole	
e: <u>11-9-95</u> .		
nesses: 1. January A. J.	elly TITE, 12 503 Garafton Ct.,	Tackson ville, florida
2. Jan- 20	O. Hisbel,	
ate Name Tabl, offis	D/G	Reference: HSB 15.02.15
# <u>090813</u> e of Birth <u>3-5-37</u>	R/S_w/m.	F.S. Ch. 765
itution FS. P.	*FROM 9544342667	

STATE OF FLORIDA DEPARTMENT OF CORRECTIONS

Attachment #1 HSB 15.02.15

Living Will

Declaration made this grh day of	Navember	,199 <u>_5</u> .
1 14	, willfully and vo- umstances set forth belo- and if my attending phys- is no medical probabili- withheld or withdrawn occess of dying, and that mance of any medical p by my family and phys- it to accept the conseque- able to provide express a	ician or treating physician and ty of my recovery from such when the application of such I be permitted to die naturally rocedure deemed necessary to ician as the final expression of neces for such refusal. Ind informed consent regarding
gate Name: Sara "Hansan		
ess: 217 N. ILTH AU: Apartment R		
ceksonwille Brach, Florida Zi	p Code: 722 Fre	
I understand the full import of this declaration, and ration. ional instructions (optional)	i I am emotionally and n	nentally competent to make this
None.		
e Signature 255 2 Graffin Ct Jackson Me Fl. Ada 1 194-24-8759) 255/Telephone Number	Witness Witness D704 Julie L Address/Telephone Nu	D. Husley 1. Middleburg, F1, 32068 imber (904) 272-5036
FROM 9544342567	(D530)	111-06-96 04:32 PM P02