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 Ottis Toole
(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 30th day of August, 1995, and to the best of his/her knowledge Testator is of lawful age, of sound mind and under no undue influence.

(1) Bettie R Stanley residing at Starke, Florida

(2) Verrell C. Martin residing at Starke, Florida

(3) Teresa K. Dowling residing at Starke, Florida

State of Florida

County of Bradford City or Town Starke

Subscribed, sworn to and acknowledged before me by the Testator Ottis Toole

and Bettie R. Stanley and Verrell C. Martin, and

Teresa K. Dowling, the witnesses, this 30th day of August, 1995.

(Seal)

GEORGE D. HALL
Notary Public, State of Florida
My Comm. expires Dec. 27, 1996
Comm. No. CC 248210

George D. Hall
(Notary Public)

Last Will and Testament

Unmarried Individual with One Beneficiary

I, OTTIS ELWOOD TOOLE #090812 presently residing at FLORIDA STATE PRISON, P.O.BOX 747, Starke,FL. 32091, do hereby make, publish and declare this to be my Last Will and Testament and do hereby revoke any and all other Wills and Codicils heretofore made by me.

First. I am an unmarried person. I do hereby give all my estate to the following named person:

SARAH CHRISTINE PATTERSON

Second. In the event that the said N/A shall predecese me, I give all of my estate to N/A.

Third. I order and direct that my just debts and funeral expenses, expenses for administration of my estate and any inheritance and succession taxes, state or federal, upon my estate shall be paid as soon after my death as may be practical.

Fourth. I nominate and appoint SARAH CHRISTINE PATTERSON as Executor/ Executrix of this Will. In the event that he/she shall predecease me or fails to survive me or fails to serve as Executor/ Executrix then I nominate and appoint N/A Executor/ Executrix of this my Last Will and Testament. I further direct that no appointee hereunder shall be required to give any bond for the faithful performance of his/her duties.

Fifth. I hereby authorize my Executor/ Executrix to exercise all the powers, rights, discretions, duties and immunities conferred upon fiduciaries to the extent permitted by law with full power to sell, lease, mortgage, invest, reinvest, or otherwise dispose of the assets of my estate, including my remains.

I subscribe my name to this Will this 30th Day of August, 1995.

x Ottis Toole
(Sign here)

Signed, sealed, published and declared to be his/her Last Will and Testament by the within named Testator in the presence of us, who in his/her presence and at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses this 30th day of August, 1995.

(1) Bettina R. Stanley of Starke (City) Florida (State)

(2) Renee C. Martin of Starke (City), Florida (State)

(3) Teresa K. Dowling of Starke (City) Florida (State)

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 NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT

Name: _____

Address: _____

Name: _____

Address: _____

SIGN AND DATE THE DOCUMENT

X Signed: Ottis Toole Ottis Toole

X Date: 9-26-95

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: David James Wells

Address: P.O. Box 747 STARKE, Florida 32091

Witness 2:

Signed: Charles Horn

Address: P.O. Box 747 Starke Florida 32091

INSTRUCTIONS

PRINT YOUR NAME

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

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

ADD PERSONAL INSTRUCTIONS (IF ANY)

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

Name: OTTIS TOOLE #090812 S-2 N-7
FLORIDA STATE PRISON
P.O.BOX 747 STARKE FL 32091-0747
(Last) *(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:

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:

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.

Additional instructions (optional):

FROM 8644142667 (D500) 11-06-96 04:32 PM P09

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

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:

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

ADD PERSONAL INSTRUCTIONS (IF ANY)

Additional instructions (optional):

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

SIGN THE DOCUMENT

X Signed: Otto Todd 9-26-95

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1: David J. Wells

Signed: David J Wells

Address: P.O. Box 747, Starke Fla 32091

Witness 2:

Signed: Charles Hon

Address: Po. Box 747 Starke Fl 32091

FLORIDA LIVING WILL

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

X Declaration made this 26 day of September, 1995.

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

PRIM 8644340887 (DSOC) 11-08-96 04:38 PM P16

BOX A OR B MUST BE COMPLETED

A

PATIENT'S SIGNATURE

I, the undersigned, hereby direct that in the event of my cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation not be initiated. I understand that I may revoke these directions at any time by physical cancellation or destruction of this form and the accompanying bracelet, or by orally expressing a desire to be resuscitated to EMS personnel; or by means of a subsequently executed advance directive that is materially different from this order. I also understand that if EMS personnel have any doubts about the applicability or validity of this order, they will begin cardiopulmonary resuscitation.

Otis Toole
Patient's Signature and Date

*WITNESSES:

OTIS TOOLE
Patient's Printed Name

1. Lawrence A. Kelly III 11-9-95
Witness's Signature and Date

Lawrence A. Kelly, III 11-9-95
Printed Name

2. Johnnee O. Kieslich 11-9-95
Witness's Signature and Date

Johnnee O. Kieslich
Printed Name

B

SIGNATURE OF HEALTH CARE SURROGATE OR COURT APPOINTED GUARDIAN OR PROXY

I, the undersigned, hereby certify that I am authorized to provide consent on the patient's behalf by virtue of my relationship to the patient as _____ (In order of priority: health care surrogate, court appointed guardian with authority to make this decision, spouse, an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation; a parent of the patient; the adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation; an adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs; or a close friend of the patient, who is 18 years of age or older who is familiar with the patient's activities, health, and religious or moral beliefs.)

In that capacity, and based upon my reasonable belief that the patient would make this same decision under these circumstances had the patient been capable, I hereby direct that in the event of the patient's cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation not be initiated. I understand that I may revoke these directions at any time, by physical cancellation and destruction of this form and the accompanying bracelet or by orally expressing a desire that the patient be resuscitated to EMS personnel; or by means of a subsequently executed advance directive that is materially different from this order. I also understand that if EMS personnel have any doubts about the applicability or validity of this order, they will begin cardiopulmonary resuscitation of the patient.

_____
Signature of Health Care Surrogate or Court Appointed Guardian or Proxy and Date

_____
Health Care Surrogate or Court Appointed Guardian or Proxy's Printed Name

*WITNESSES:

1. _____
Witness's Signature and Date

_____
Printed Name

2. _____
Witness's Signature and Date

_____
Printed Name

*The subscribing witnesses must sign in the presence of the patient, or health care surrogate or proxy or guardian and each other.

Effective Date: 11-9-95

STOP

DO NOT RESUSCITATE

Florida
Prehospital Do Not Resuscitate Order (DNRO)

Patient's Full Legal Name Otis Elwood O'Toole JR.
(Please Print or Type)

ATTENDING PHYSICIAN'S ORDER

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, Florida Statutes (F.S.), state that I am the attending physician of the patient named above. I have documented in the patient's medical record that: (must check 1 or 2)

☑ 1. The patient is CAPABLE of making an informed decision and consent about providing, withholding or withdrawing a specific medical treatment or course of treatment. (Signature of patient is required in Box A, reverse side).

☐ 2. The patient is INCAPABLE of making an informed decision and consent about providing, withholding or withdrawing a specific medical treatment because the patient is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision. I have made this determination after consultation with a second physician licensed under Chapter 458 or 459, F.S.

If box 2 above is checked, (patient is INCAPABLE of making an informed decision), either 1, 2, or 3 below must be checked;

☐ 1. The patient has executed a written advance directive which directs that life-prolonging procedures be withheld or withdrawn (Signature of surrogate or proxy or guardian is required in Box B, reverse side and a copy of the advance directive must be attached).

☐ 2. The patient has executed a written advance directive which appoints a health care surrogate pursuant to Chapter 765, F.S., to make health care decisions on behalf of the patient and provides that surrogate with authority to direct that life-prolonging procedures be withheld or withdrawn (Signature of the appointed surrogate is required in Box B, reverse side and a copy of the advance directive must be attached).

☐ 3. The patient has NOT executed a written advance directive (living will, designation of a health care surrogate or durable power of attorney for health care). (Signature of guardian, if one has been appointed, or proxy, pursuant to Chapter 765, Part IV, F.S., is required in Box B, reverse side).

Based upon the informed directive, decision and consent on the reverse side, I hereby direct any and all emergency medical services personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation, and other advanced airway management, artificial ventilation, defibrillation and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide to the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.

Signature of Attending Physician and Date

(904) 964 8125
Telephone # (Emergencies)

JORGE FRANCESCHI-ZAMBRANA, M.D.
MEDICAL EXECUTIVE DIRECTOR,
FLORIDA STATE PRISON
Printed Name

MLTL 000054
Physician's Medical License Number

☑ This DNRO form has been properly completed.

Signature of Patient or Surrogate or Proxy or Guardian

If the patient should die at home while EMS is present or during transport by EMS personnel, the EMS provider shall document in the narrative portion of the patient's EMS run report the information required in section 10D-66.325(9), F.A.C.

DS Form 1896, Oct '93
DH-667 (4/94)

THIS SIDE MUST BE COMPLETED

(OVER)

FROM 9644342667 (DEOD) 11-06-96 04:32 PM P04

005784

STATE OF FLORIDA
DEPARTMENT OF CORRECTIONS

Designation of Health Care Surrogate

ne: (Last) Tool (First) Ottis (Middle Initial) E.
In the event that I have been determined to be incapacitated to provide informed consent for
tment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

ne: Sara Patterson

lress: 217 N. 16th Ave, Apartment B

Jacksonville Beach, Florida Zip Code: 32250

me: _____

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

ne: _____

lress: _____

_____ Zip Code: _____

me: _____

I fully understand that this designation will permit my designee to make health care decisions and to
vide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health
e; and to authorize my admission to or transfer from a health care facility.
litional instructions (optional): None.

I further affirm that this designation is not being made as a condition of treatment or admission to a health
e facility. I will notify and send a copy of this document to the following persons other than my surrogate,
hey may know who my surrogate is.

ne: _____

ne: _____

ned: Ottis Tool

e: 11-9-95.

nesses: 1. Deanna A. Hall-Tu, 12503 Carrotton Ct, Jacksonville, Florida

2. Johnnie O. Hartsfield,

ate Name Tool, Ottis

090812 R/S W/M

e of Birth 3-5-37

itution F.S.P.

Reference: HSB 15.02.15
F.S. Ch. 765

FROM 9544342687 (800) 11-08-96 04:32 PM P03

STATE OF FLORIDA
DEPARTMENT OF CORRECTIONS

Attachment #1
HSB 15.02.15

Living Will

Declaration made this 9th day of November, 1995.

Otto Toole, willfully and voluntarily make known my desire
ny dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time I should have a terminal condition and if my attending physician or treating physician and
er consulting physician have determined that there is no medical probability of my recovery from such
tion, I direct that life-prolonging procedures be withheld or withdrawn when the application of such
dures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally
only the administration of medication or the performance of any medical procedure deemed necessary to
de 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
gal 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
ithholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate
ry out the provisions of this declaration:

gate Name: Sara V. Hinson

ess: 217 N. 11th Ave., Apartment B

cksonville Beach, Florida Zip Code: 32250

e: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this
ration.

ional instructions (optional):

None

Otto Toole
e Signature

ess
2 Grafton ct Jacksonville, Florida 1904-241-8759)
ess/Telephone Number

Witness
6704 Julie Ln. Middleburg, Fl. 32068
Address/Telephone Number (904) 272-5036