

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 2002-624

INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

020698

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

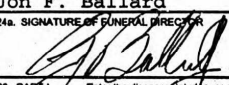
INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED - NAME (First, Middle, Last) Betty Jean Musick		2. SEX Female		3a. TIME OF DEATH 9:25 pm		3b. DATE OF DEATH (Month, Day, Yr.) June 26, 2002	
5a. AGE - Last Birthday (Years) 77		5b. UNDER 1 YEAR Months _____ Days _____		5c. UNDER 1 DAY Hours _____ Minutes _____		8. DATE OF BIRTH (Mo., Day, Yr.) May 29, 1925	
7. BIRTHPLACE (City and State or Foreign Country) Alexandria Indiana		PLACE OF DEATH (Check only one - See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input checked="" type="checkbox"/> Residence OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) _____					
9a. WAS DECEDENT A U.S. VETERAN? No		9b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9c. CITY, TOWN, OR LOCATION OF DEATH Daleville			
9d. COUNTY OF DEATH Delaware		10. MARITAL STATUS (Specify) Married					
11. SURVIVING SPOUSE (If wife, give maiden name) Herschel Musick		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Supervision		12b. KIND OF BUSINESS/INDUSTRY K-Mart			
13a. RESIDENCE - STATE Indiana		13b. COUNTY Delaware		13c. CITY, TOWN OR LOCATION Daleville		13d. STREET AND NUMBER 14921 4rth Street	
13e. ZIP CODE 47334		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A					
18. FATHER'S NAME (First, Middle, Last) Elijah Elora Davis				19. MOTHER'S NAME (First, Middle, Maiden Surname) Irene King			
20a. INFORMANT'S NAME (Type/Print) Herschel Musick		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14921 4rth Street, Daleville, IN 47334		20c. Relationship Husband			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) _____		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) July 2, 2002 Parkview Cemetery		21c. LOCATION - City or Town, State Alexandria, Indiana			
22a. EMBALMER'S NAME Jon F. Ballard		22b. EMBALMER'S LICENSE NO. 01010004		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) 01018476		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Ballard & Sons Funeral Home, 83001300 8212 South Walnut Street, Daleville, Indiana			
26. PART I Enter the disease, injury, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Bronchogenic CANCER DUE TO (OR AS A CONSEQUENCE OF): _____ b. Sp uterine CANCER DUE TO (OR AS A CONSEQUENCE OF): _____ c. emphysema DUE TO (OR AS A CONSEQUENCE OF): _____ d. _____ PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE, AND PLACE, AND DUE TO THE CAUSE(S) AS STATED. <input type="checkbox"/> HEALTH OFFICER 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) AS STATED. <input type="checkbox"/> CORONER 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) AS STATED.							
29b. SIGNATURE AND TITLE OF CERTIFIER Richard A. Reedy, M.D.		29c. MEDICAL LICENSE NO. 01082314		29d. DATE SIGNED (Month, Day, Year) 7-1-02			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Richard A. Reedy, M.D. 1480 S. Pilgrim Blvd., Yorktown, IN 47396							
31. HEALTH OFFICER'S SIGNATURE Donna A. Dickins, M.D.		32. DATE FILED (Month, Day, Year) JUL 1 2002					
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)	
34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.					

TIME 28 2002