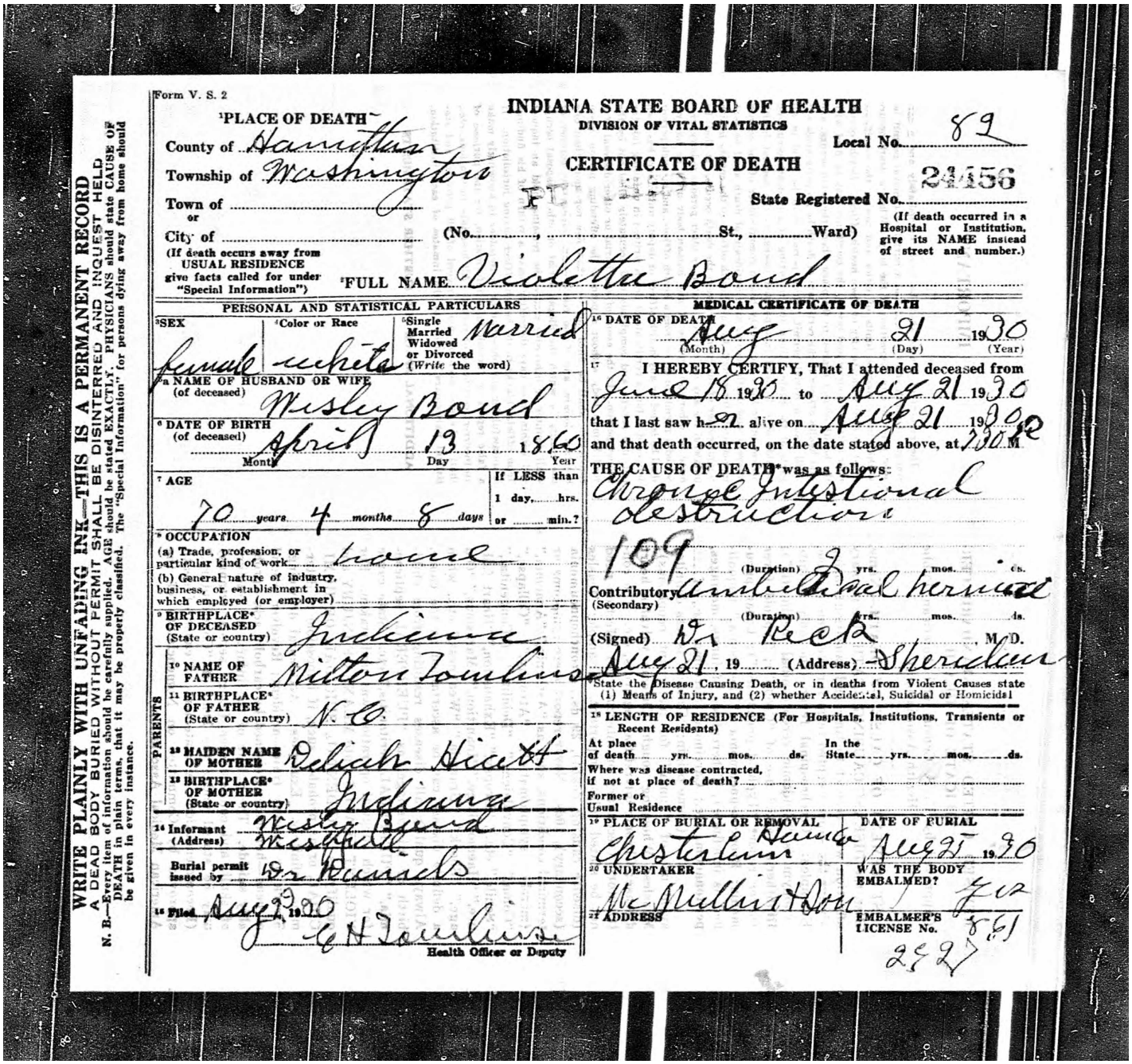

Form V. S. 2

INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL STATISTICS

Local No. 89

CERTIFICATE OF DEATH

State Registered No. 24156

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
A DEAD BODY BURIED WITHOUT PERMIT SHALL BE DISINTERRED AND INQUEST HELD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, that it may be properly classified. The "Special Information" for persons dying away from home should be given in every instance.

[1]PLACE OF DEATH
County of Hamilton
Township of Washington
Town of ..... or
City of ..... (No. ....., ... St., ... Ward)
(If death occurs away from USUAL RESIDENCE give facts called for under "Special Information")
(If death occurred in a Hospital or Institution, give its NAME instead of street and number.)

[2]FULL NAME Violetta Bound

PERSONAL AND STATISTICAL PARTICULARS

[3]SEX: female
[4]Color or Race: white
[5]Single, Married, Widowed or Divorced (Write the word): Married
[6a]NAME OF HUSBAND OR WIFE (of deceased): Wesley Bound
[6]DATE OF BIRTH (of deceased): April 13 1860 (Month, Day, Year)
[7]AGE: 70 years 4 months 8 days. If LESS than 1 day, ... hrs. or ..... min.?
[8]OCCUPATION
(a) Trade, profession, or particular kind of work: home
(b) General nature of industry, business, or establishment in which employed (or employer):
[9]BIRTHPLACE* OF DECEASED (State or country): Indiana

PARENTS
[10]NAME OF FATHER: Milton Tomlinson
[11]BIRTHPLACE* OF FATHER (State or country): N. C.
[12]MAIDEN NAME OF MOTHER: Delilah Hiatt
[13]BIRTHPLACE* OF MOTHER (State or country): Indiana

[14]Informant (Address): Wesley Bound Westfield
Burial permit issued by: Dr Runnels
[15]Filed Aug 2 1930
E H Tomlinson
Health Officer or Deputy

MEDICAL CERTIFICATE OF DEATH

[16]DATE OF DEATH: Aug (Month) 21 (Day) 1930 (Year)
[17]I HEREBY CERTIFY, That I attended deceased from June 16 1930 to Aug 21 1930
that I last saw h-2 alive on Aug 21 1930
and that death occurred, on the date stated above, at 7:30 P M
THE CAUSE OF DEATH* was as follows:
Organic Intestinal destruction
109
(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Umbilical hernia
(Duration) yrs. mos. ds.
(Signed) Dr Reed M.D.
Aug 21 1930 (Address) Sheridan
*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal

[18]LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or Usual Residence

[19]PLACE OF BURIAL OR REMOVAL: Chesterfield
DATE OF BURIAL: Aug 25 1930
[20]UNDERTAKER: McMullin & Son
WAS THE BODY EMBALMED? Yes
[21]ADDRESS
EMBALMER'S LICENSE No. 861 2527